University Hospitals Plymouth NHS Trust

Derriford Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Derriford Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Derriford Hospital.

We inspected the maternity service at this 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 announced, focused inspection of the Maternity service, looking only at the safe and well led key questions.

University Hospitals Plymouth NHS Trust manages the maternity services at Derriford Hospital. The maternity unit comprises of a central delivery suite, combined ante- and postnatal ward, day assessment unit and maternity triage unit, as well as midwife and consultant-led clinics, fetal medicine and scanning services. The hospital also provides community midwifery services.

From 1 September 2021 to 31 August 2022 there were 3,692 babies born at the hospital.

This focused inspection reviewed the domains of safe and well led using CQC's established key lines of enquiry (KLOES).

How we carried out the inspection

The inspection was carried out using a post-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, a review of hospital policies, and review of care records and documentation. Following the site visit we conducted interviews with senior leaders and reviewed patient feedback about the trust made directly to CQC via our routine enquiries process.

We visited the clinical areas of the labour ward, triage, maternity day assessment unit, clinics, fetal medicine/scanning and the ante- and postnatal ward.

We spoke to 20 staff, and to senior leaders and specialists to better understand what it was like working in the service. We spoke to midwives, obstetric staff, support workers, practice development midwives, and the patient safety team.

We interviewed leaders to gain insight into the trusts group leadership model and governance of the service.

We attended ward handovers, safety huddle meetings, and a situation and risk meeting.

Our findings

We spoke to 5 women and families who were currently being cared for by the trust to gain insight into their experience of care. We also received in excess of 100 online enquiries from women and families who had received care at Plymouth Hospitals' NHS Trust in the previous few months.

We reviewed 5 sets of maternity records and 8 prescription charts.

We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recently reported incidents and audit results.

After the inspection we requested further documentary evidence to support our judgements including policies and procedures, staffing rotas 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

Requires Improvement

Our rating of this location is requires improvement because:

- There was a standard operating procedure in place for maternity triage however, the service did not have an evidence-based, standardised system to prioritise and review women attending for urgent maternity care. There was no process to support staff in prioritising care in triage for those that are most in need.
- The service did not always have enough staff to care for women and keep them safe. Staff did not always receive training in key skills. Staff did not always assess risks to women nor act on them. Staff did not always keep contemporaneous care records. The service did not always manage safety incidents well or learn lessons from them.
- Leaders ran services without applying all available information systems. Leaders and executives were not visible and communicative to ward staff.

However:

- Service-level staff worked well together for the benefit of women. Staff managed medicines well.
- Leaders supported staff to develop their skills and completed annual appraisals. Staff understood the service's values, and how to apply them in their work. Managers sometimes monitored the effectiveness of the service.
- Service-level staff had good relationships with their teams, and teams supported each other. Staff were clear about their roles and accountabilities. The service engaged with women and the community to plan and manage services. Women could access the service when they needed it. Staff were committed to improving services.

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff however did not make sure everyone completed it.

Maternity staff did not always receive and keep up to date with their mandatory training. Staff did not complete regular skills and drills training. Data showed 30% of midwives had completed birth pool evacuation training. The trust told us that this was due to limitations caused by the COVID-19 pandemic and that it would be added to the risk register. Training compliance data submitted by the trust was in several various documents, layouts and formats, the impact of this was that compliance levels were difficult to keep track of, and therefore we were not assured that managers had adequate oversight of the data. The impact of this is that staff are not always up to date in providing safe care. Managers told us that they monitored mandatory training and alerted staff when they needed to update their training, but staffing pressures had resulted in reduced training compliance. Compliance was below trust target levels for mandatory training modules including: resuscitation, safeguarding, local trust update, cardiotocograph (CTG, or continuous electronic fetal monitoring) training for doctors, evacuation procedure from the birthing pool, newborn life support (NLS), practical obstetric multi-professional training (PROMPT), patient group directive (PGD: training for midwife prescription and administration of specific medicines) and infection prevention and control training.

Maternity

The mandatory training package was comprehensive and met the needs of women and staff when it was completed. However, staff did not receive human factors training. This was not in line with national guidelines, or the recommendations made in the most recent Ockenden early immediate actions (2020, 2022). The trust told us that there were plans to add specific human factors training into PROMPT study days.

Staff received training on interpreting and acting upon outcomes of CTG monitoring of the fetal heart. Staff accessed a nationally recognised E-learning package on CTG interpretation, which was comprehensive and covered fetal monitoring and maternity crisis management. Staff completed a competency test at the end of the training to make sure that learning was embedded. Records showed CTG training compliance for doctors was 76% and midwives 94%. The service target for CTG training compliance was 85%. Staff completed training on recognising and responding to women with mental health needs.

The service ran 'pop-up' training stations in the clinical areas to support colleagues with upkeep of key skills, such as perineal suturing; recognising that it may be difficult for staff to leave wards to attend more formal style training days. Specialist midwives covered the workload to facilitate staff having time away from clinical care to attend these sessions.

Safeguarding

Not all staff understood how to protect women from abuse nor did the service work well with other agencies to do so. Not all staff had required training on how to recognise and report abuse.

Midwifery staff had not all received training specific for their role on how to recognise and report abuse. We saw two documents of partial data showing that 86% and 88% of midwives were trained to level 3 safeguarding. The trust data was unclear on target compliance, some documents stated 85% and others stated 90% target rate. We saw the training level provided to staff complied with the intercollegiate guidelines (2019).

Safeguarding training records for medical staff submitted by the trust was unclear and therefore compliance levels were unknown. Intercollegiate guidelines (2019) state that all staff planning care for children and adults must be trained and complaint in level 3 safeguarding.

Support workers and administrative staff attended E-learning level 1 and 2 safeguarding sessions. Managers gave them protected time to complete this.

Staff were not always able to give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act however, staff did tell us that they would refer to the safeguarding policy.

Not all midwives and doctors were able to tell us how to make a safeguarding referral and who to inform if they had concerns. Some staff told us that all safeguarding issues were managed by the community safeguarding midwives. Staff we spoke to were not able to show us how the process of identifying a concern and making a safeguarding referral was done. We did not see any formalised processes to ensure adults and children with safeguarding concerns were identified and managed appropriately when attending the service. The lead midwife for safeguarding had not received the appropriate level of training. The trust told us that specialist safeguarding training was booked for April 2023.

Doors to the wards were locked and secure, and there was an abduction policy in place. There were no security breaches within the past year.

Maternity

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw there was enough equipment available for staff to keep patients safe. There was evidence of compliance in hand hygiene audits between June and August 2022 of over 99%. Mandatory training levels in infection prevention and control was 85% in the three months prior to the inspection.

Leaders monitored nosocomial (hospital acquired) and sepsis infections. Records showed that between April and September 2022 there were 2 incidents of *C. difficile* and 1 incidence of *MRSA*, which was managed by infection control leads.

The service controlled *Legionella* infection risk well. We saw records of water source flushing to reduce the risk of water-borne infections such as *Legionella* was 100% within maternity.

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after contact with women and mostly labelled equipment to show when it was last cleaned.

A significant number of patients told us through online feedback forms that there was often dirty linen visible on wards that was not taken away or stored appropriately. However, we did not see evidence of this on the day of inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment did not follow national guidance. For example, clinics and waiting areas for postnatal women and their babies were alongside the early pregnancy unit, and there was no co-located midwife led unit for low-risk birth. The service recognised this impacted negatively on women's experience of the service and told us they were working on ways to resolve it.

We saw logbooks that described out of date equipment to be replaced, with no clear record that this was completed. We found some out of date equipment on the labour ward, including adult electrocardiogram (ECG) leads, ECG pads and manual resuscitation equipment. We saw evidence of some daily checks that were not completed. Staff mostly carried out daily safety checks of specialist equipment. We saw evidence that between July and September 2022, compliance for equipment checking within the unit was between 93% and 99%.

The service had facilities to meet the needs of women's families. The labour ward had 14 rooms including a birth pool. There were two high dependency rooms. There were two bereavement rooms in a more private area of the labour ward. At the time of inspection, there was no co-located midwife-led unit for women to receive low-risk intrapartum care.

Maternity

The service had enough suitable equipment to help them to safely care for women and babies including CTG machines and resuscitaires in every room on labour ward, as well as on the maternity ward. Staff on the postnatal ward had access to a bilirubinometer which is a non-invasive equipment that monitors babies for jaundice. This is in line with best practice guidance. There was a portable ultrasound device on labour ward and on the maternity ward for staff to use prior to commencing any intervention.

Staff disposed of clinical waste safely.

Women could reach call bells and staff responded when called.

Assessing and responding to patient risk

Staff did not complete or update risk assessments for each woman.

There was no formalised, standardised, evidence-based method of risk assessment used in the maternity triage or labour ward setting.

The triage unit did not use a standardised, evidence-based tool or system to identify women at risk of deterioration or to prioritise their care appropriately. We escalated this to the service at the time of inspection, the service told us that an attempt to implement a standardised tool had been unsuccessful, and that the implementation of a new IT system in 2023 would provide a solution.

There was a standard operating procedure in place for maternity triage. Women attended triage following invitation by a midwife over the phone; during the daytime phone calls were taken by midwives working in the local ambulance call handling centre, and details were shared with the service using a computer system. The service was not always able to monitor, assess and review women in a timely way.

Staff did not always complete risk assessments for women during their booking appointment and antenatal care. We reviewed five sets of records and saw three out of five records did not have regular risk assessments during the antenatal period, this was not in line with national guidance. None of these women had received a risk assessment when they attended maternity triage or were admitted to labour ward, this was not in line with national guidance.

We asked the trust for assurance around processes in triage following the inspection, the trust told us that it had taken urgent action to implement a standard prioritisation process.

Staff knew about and dealt with any specific risk issues such as sepsis and venous thromboembolism (VTE). Staff completed Modified Early Obstetric Warning Score (MEOWS) charts. We saw MEOWS charts were clear and identified women whose condition was deteriorating. During our inspection we observed that midwives escalated findings to doctors for review, however, we noted there were occasions when reviews were delayed due to capacity and medical and midwifery staffing issues.

Staff monitored fetal wellbeing using a cardiotocograph (CTG) machine. We saw evidence that pre-populated stickers that followed national guidelines to assess fetal wellbeing were available, however these were not always used, completed in full, or signed. Staff used a ‘fresh eyes approach’ to review CTG progress, and the trust had appointed a fetal wellbeing midwife to support staff training and decision making. We escalated this to the service at the time of inspection and were told that regular audits were performed to monitor compliance. We saw CTG audits from May to

July 2022 to check patient details and hourly 'fresh eyes' reviews. The trust audited 40 sets of notes per month and compliance was variable between 85.2% and 100%, the trust target compliance was 100%. The recommendation from the audit was to recirculate relevant guidance to staff as a reminder of required standards of documentation, and to continue regular audit cycles.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff completed or arranged psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Staff completed multidisciplinary (MDT) shift handovers in two key areas: antenatal and postnatal ward, and labour ward. Shift changes and handovers included all necessary key information to keep women and babies safe.

Staff shared key information to keep women safe when handing over their care to others. Staff did not always use a formalised tool such as SBAR (situation, background, assessment, and recommendation) process to handover care however we saw that handovers did contain relevant information required.

Staff used some nationally recognised care bundles to assess women during pregnancy. For example, the 'Saving Babies' Lives Version 2 (2019)', which is an evidence-based bundle of care designed to reduce the numbers of stillbirth and early neonatal deaths bringing together five elements which are identified as best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth

We saw the service used 'Gap Grow' charts however, evidence showed that trust-wide the 'Gap Grow' care pathway did not always follow national guidelines. The service was unable to provide a time frame for a review of this care pathway to align with national guidelines, in part due to a shortage of sonographers to support its implementation. This was recognised on the service risk register. Women assessed as being at higher risk of pre-term birth at booking were assigned to the consultant led care pathway, and scans were offered out of guidelines at 28 weeks gestation to mitigate lack of conformity to the national care pathway.

The service completed audits on performance against 'Saving Babies' Lives v2' and records from May 2022 to July 2022 showed high levels of compliance against elements 2 and 3. Compliance for monitoring and reducing smoking during pregnancy and effective fetal monitoring in labour was variable and below trust targets in several areas, including referral to smoking cessation, carbon monoxide monitoring and risk assessment to ensure appropriate fetal monitoring takes place during labour.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels to ensure key areas were staffed appropriately most of the time. The service gave bank staff an induction.

Maternity

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

The service did not have enough midwifery or support staff to keep women and babies safe and we saw there was high vacancy and sickness rates. Evidence provided by the trust showed there was a current shortfall of 12.45 whole time equivalent midwives following the most recent maternity staffing review in January 2022. Maternity staffing levels was entered onto the trust risk register and recruitment was ongoing at the time of inspection. Since the inspection the trust told us further recruitment had been successful and the vacancy rate improved.

Managers calculated and reviewed the number and grade of midwives, maternity assistants and nurses needed for each shift in accordance with national guidance. The service had on-call rotas in place to manage escalation, these were mainly self-rostered by staff and the hours worked were in addition to their contracted weekly hours. We were told that midwives typically had 2 escalation on-call shifts per month. The trust results from the NHS Staff Survey 2021 showed that 89% of midwives had worked additional hours unpaid, and that 60% of midwives had worked additional hours and been paid for them.

Evidence provided showed staffing levels and capacity concerns led to delays in induction of labour. Staff told us there were times when managers had to make the decision to postpone care for women who were due to have an induction of labour or elective caesarean. The service had staggered admission times for women booked for induction of labour to ease some of the activity and managers completed a daily review of the elective caesarean operating. Managers and obstetricians reviewed women to prioritise the most urgent, then contacted mothers whose care could be delayed for a short period, for example 24 hours. Staff gave women their new appointment time and advice in the event of an emergency. During the inspection there was a delay in the induction of labour process, and it was not clear that there was an effective system in place to manage and escalate delays. Delays and poor communication between staff and patients regarding induction of labour was a theme from patient feedback submitted to the CQC, and 86% of maternity 'red flag' incidents recorded between 17 January and 18 June 2022 were in relation to delays in induction of labour. This had not been identified as a risk nor added to the risk register for monitoring and review. After the inspection, we asked the trust for further information regarding delays in IOL. They provided a clear escalation policy and provided evidence that women experiencing delayed IOL were reviewed twice per day.

Records showed that staffing issues had been ongoing. Managers attempted to backfill gaps in rotas using bank staff however between 3 April and 25 September 2022, there were 821 shifts (57%) where this was not possible.

The trust had recently employed 19 newly qualified midwives to improve staffing levels. Newly qualified midwives were offered three supernumerary shifts on the labour ward at the start of their employment. We escalated the issue of potential skill mix dilution on the day of inspection. To avoid skill mix dilution and provide supernumerary shifts as per policy, we were told that newly qualified midwives had their start dates staggered at one-week intervals.

There was not always a supernumerary shift co-ordinator on labour ward to ensure staff were well supported and care was safe. This is one of 10 Clinical Negligence Scheme for Trusts (CNST) accreditation requirements. Records showed 48% of the time labour ward had one or no senior midwife on duty, with no second senior midwife to provide a 'helicopter view' of the unit. We were told that acuity and staffing was such that there were occasions where women had not had one-to-one care in labour, and that senior midwives were not supernumerary and had been required to provide labour care. The impact of this is that there is no objective oversight of capacity and acuity on the unit. However, since inspection the trust told us this rarely happens and have recorded this to be on just 2 occasions in the last 12 months when the matrons or the Head of Midwifery provided cover.

Maternity

Data showed there were at least three occasions where one-to-one care was not able to be provided to a woman in labour, however the data was incomplete, maternity 'red flags' may not be reported or recorded appropriately.

The ward manager could adjust staffing levels daily according to the needs of women, and the service calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance.

Ward managers attended daily staffing handovers and discussed the acuity of their patients. Matrons were identified as the decision makers for staff moves within the unit. Staff told us if labour ward was busy staff were moved to support the number of women in labour however, this meant there was reduced staffing on the antenatal and postnatal ward, which posed the risk of impact on patient care.

Managers made sure all bank staff had a full induction and understood the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that they had regular appraisals and sometimes found them useful.

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 most of the time.

The service reported that they had enough medical staff to keep women and babies safe. The service employed 18 consultants across obstetrics and gynaecology, 14 consultants provided out-of-hours (night-time and weekend) work.

The service provided a comparably large amount of consultant presence without routine use of locum doctors; there was an allocated on-site consultant for labour ward every day from 8am until 1pm, when services are joined with gynaecology, and a resident consultant rota provided night-time cover. The service was able to provide this because consultants regularly worked more than their contracted weekly hours. Evidence provided by the service showed that 13 out of 18 consultants were routinely allocated over the recommended amount of programmed activity. Staff told us that there were times when sickness had resulted in consultants covering long hours to meet the needs of the service at a detriment to their health and wellbeing and this potentially had impact on clinical decision-making.

The January 2022 maternity staffing review identified a shortfall of 2.6 full-time equivalent consultants. We escalated obstetric staffing to the trust at inspection and they told us that there were plans for further recruitment however, there was a recognised issue with attracting and retaining staff in the South West of England. The service had completed an analysis of medical staffing and had made a business case to fund extra staff.

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

The service made sure locums and junior doctors had a full induction to the service before they started work. Junior medical staff told us they felt well supported and that lines of escalation are clear.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Consultants were responsible for supporting doctors to progress. Staff told us that they were well supported in terms of their clinical work and they had access to multi-professional teaching.

Managers could access locums when they needed additional medical staff.

Maternity

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Records

Staff kept detailed records of women's care and treatment. Records were not always clear, up-to-date, or stored securely.

The service used paper records provided by the perinatal institute and used an out-of-license IT system to record hospital admissions. In the ante- and postnatal period staff recorded care in the mothers' handheld notes and used proformas. Labour documentation was handwritten, and basic information was input into the IT system after the birth. This meant that records were difficult to maintain and audit. We reviewed 5 sets of notes during the inspection and found that staff recorded care contemporaneously in the paper records however, notes were not consistent, and did not always contain required information. For example, Modified Obstetric Early Warning Signs (MEOWS) charts were not fully complete, risks were not always documented, documentation around CTG monitoring was incomplete in 3 out of 4 records where the woman had electronic fetal monitoring, and entries made were not always signed appropriately, particularly by medical staff.

Women's notes were not always comprehensive, and it was difficult for staff to access them due to having no electronic access.

Managers completed monthly record keeping audits and records showed that staff reviewed 30 sets of notes at each audit. The service supplied one record keeping audit; audits aimed to highlight omissions and areas for improvements. The audit showed that record keeping was satisfactory and noted some areas for improvement, for example: ensuring clinicians identify the lead professional, student entries are countersigned by a registered professional, and that fluid balance and baby feeding charts should be completed appropriately. However, audit records provided by the service relating to the Saving Babies Lives care bundle showed that there were other areas of record keeping that required improvement, for example documenting carbon monoxide levels and appropriately recording maternal observations and CTG interpretation in labour.

Records were stored securely most of the time. There were lockable cabinets for notes on wards, however we saw that sometimes these were left open or not working. During clinics, notes were made available to clinicians and placed in unattended open trolleys in corridors which is not compliant with data protection laws.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines. Medicines training and documentation was not always completed appropriately.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed the trusts standard operating procedure when prescribing medicines.

Staff were required to demonstrate their own competencies in medicines management and attend annual updates. The trust did not provide evidence of specific competencies or training provided to staff. Training records provided by the service for medicines management of Patient Group Directive (PGD) medicines, (a group of medicines that can be administered by midwives without the need for a doctor or nurse prescriber) contained partial data therefore we were

not assured that the service has adequate oversight of training needs and compliance. Evidence provided for the year ending April 2022, showed 126 out of 182 midwives had completed the required training. This equates to a 69% compliance rate, which is below the trust target of 85%; this meant the service could not be assured all midwives were up to date on correct administration of PGD medicines which could result in errors.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Staff did not always complete medicines records accurately and keep them up to date; we found one out of five sets of notes contained omissions from the medications records, and two out of five notes contained prescriptions that were not adequately legible. All the records we reviewed did not have the woman's weight recorded on the prescription chart.

Staff stored and managed all medicines and prescribing documents safely. Managers held keys for the controlled drugs (CD) cabinet in accordance with, the Misuse of Drugs Regulations (2001). The contents were checked at each shift change in line with the hospitals policy and outcomes recorded in the CD record log. Records showed checks were completed and correct.

Staff followed national practice to check women had the correct medicines when they were admitted or moved between services.

The service ensured women's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service did not always manage safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents however did not always adequately share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff showed they understood the various types of incidents that occurred throughout maternity and knew how to escalate their concerns and how to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff followed trust guidelines on how to identify and report incidents. Staff accessed an electronic reporting system to complete incident reports. The responsibility of reporting incidents within maternity was shared between medical and midwifery staff.

Three maternity related serious incidents were reported by the trust from 1 February 2022 to 21 June 22 and were investigated in line with trust policy. During inspection we found evidence that incidents were not always categorised appropriately for future learning. For example, we reviewed an incident where a patient was readmitted to theatre due to complications, and this was not appropriately categorised.

The service used an online Perinatal Mortality tool to report serious incidents trust wide. The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths and produced a biannual Perinatal Mortality Reviews Summary Report (PMRT). The total number of perinatal deaths reported to MBRRACE-UK perinatal mortality surveillance from 1 March 2022 to 31 August 2022 was 14. Leaders categorised reporting based on the gestation of the mother. For example, under 23 weeks gestation to over 37 weeks gestation

Maternity

Managers sometimes shared learning with their staff about incidents within the trust via email newsletters and 'theme of the week' posters. During the inspection we found that there had been no 'theme of the week' shared learning for over a month. We saw evidence of three service newsletters dating from April 2022 to August 2022 that contained learning points from incidents. We attended handovers during inspection and no safety huddle or shared learning from incidents took place, and staff that we spoke to were not able to give examples of recent learning.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong.

Staff did not always receive feedback following the investigation of incidents, both internal and external to the service. Staff told us that feedback may be received if they were directly involved in a serious incident, and trust-wide feedback was less usual.

Managers investigated incidents. Women and their families were involved in these investigations. Leaders followed a process for reviewing and rating incidents. Records provided by the trust showed that on 28 September 2022 there were 130 open incidents, and of these at least 61 were over 60 days old. However, the data provided was partial and totals within the data were incorrect, therefore did not demonstrate accurate oversight of incidents awaiting management.

Managers debriefed staff after any serious incident. The service provided an initiative to support staff involved in adverse incidents called SUSTAIN; incidents could be logged using a QR code and staff were contacted by a multi-disciplinary support team including a psychologist. The service was planning to present this as best practice at an NHS England conference. Staff told us that they felt well supported by their colleagues if they were involved in incidents.

We asked the service for any evidence that changes and improvements had been made following feedback from patients, however this was not provided.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders understood and managed some of the priorities and issues the service faced. They were not always visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.

University Hospitals Plymouth NHS Trust operated a multi-level leadership model. There was a trust board, a chief executive, and a clinical board that oversaw the work of maternity services and newborns.

The maternity leadership team included clinical directors, director of maternity services, head of midwifery, and a general manager. This was supported by a non-executive director (NED) safety champion, the safety champion for maternity services who was also the hospital chief executive, and the vice-chair of the Maternity Voices Partnership.

Maternity

Leaders told us that they felt well supported by the trust board and that maternity services updated the board regularly about specific issues and workstreams. Staff told us the immediate ward managers were visible and approachable however; they did not always know who senior leaders were and they did not think senior leaders would always act on concerns raised. This was corroborated by results of the NHS Staff survey in which 40% of staff felt that the organisation would act on concerns raised.

The head of midwifery at the trust managed two maternity matrons. The service did not employ a consultant midwife however leaders told us that recruitment for this post was planned. Specialist midwives reported to the maternity matrons or the head of midwifery.

Professional midwifery advocate roles had been established throughout maternity services.

Vision and Strategy

The service did not have a vision for what it wanted to achieve nor a strategy to turn it into action.

There was a lack of clear vision and strategy for maternity services. Staff were not aware of the maternity services vision and leaders had not implemented a strategy in order to drive improvements and measure progress. We spoke to leaders during the inspection and they told us that the trust was working on vision and strategy in conjunction with the LMNS and the maternity voices partnership (MVP) however, there was no timescale for production and implementation provided.

Leaders told us that the trust strategy would be focused on the implementation of recommendations within the Ockenden reports, workforce planning, and improving engagement with patients and external stakeholders such as the maternity voices partnership; as well as a business case for a midwife-led unit to support women's birthplace choices and access to low-risk maternity care.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Women, relatives and carers knew how to complain or raise concerns and information on how to do so was readily available online.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated and responded to complaints. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was sometimes used to improve the service. Staff told us that learning was shared via email but they did not always have time to read the information; staff were not always aware of recent complaints and learning, and told us that learning was not disseminated throughout the multi-disciplinary team well enough.

Staff could not give examples of how they used women's feedback to improve daily practice.

Maternity

As part of our inspection, women told us online that staff were sometimes rude and uncaring, and that staff seemed too busy to care, especially on the ante- and postnatal ward, and throughout the induction of labour process. Women told us that they often had to wait or ask repeatedly for pain relief, and for updates on their plan of care. This theme was reflected in the official complaints received; the trust did not provide data to show what it had done to address this theme. However, women told us that they felt well cared for, supported and listened to whilst they were on the labour ward.

In the 2021 NHS Staff Survey, maternity services at the trust scored lower than the trust average on all nine questions including topics such as continuous learning, safety, and staff morale. The staff survey results showed that staff did not always feel valued by the organisation, however gained support from their immediate colleagues. This was reflected in our staff interviews. Survey results showed that staff felt frustrated and burnt-out at work, with little energy left for their personal lives. Staff said that managers did not always listen to their concerns. On the day of the inspection staff told us that culture had improved recently and that they felt supported by their team and their direct line managers. Staff told us that they did not always escalate concerns to senior leaders as although they felt safe to do so, they did not always know who to approach, nor feel that concerns would be acted upon. There was a disconnect between organisational leadership and service staff, with no clear lines of communication or escalation between the two levels.

The General Medical Council National Trainee Survey (GMC NTS) 2022 survey completed by medical trainees for obstetrics and gynaecology (programme group) results were high scoring in overall satisfaction and clinical supervision.

Trainee doctors told us that they had found their placement to be interesting and they had learned a lot about caring for high risk patients. They felt escalation pathways were clear and that they were well supported by clinical and midwifery colleagues.

Senior doctors told us that they felt burnt out and did not feel that leaders had full understanding into the extent of their workload. Staff felt pressured to work to help to cover sickness and absence to ensure the needs of the service were met; this led to staff regularly working additional hours. Some doctors told us there was less clarity within the obstetric leadership structure than in gynaecology, and that there was a lack of parity with senior doctors in other parts of the organisation. Staff told us that there was not clear communication from leaders to address these issues.

University Hospitals Plymouth NHS Trust was categorised 'as expected' overall in the 2021 CQC Maternity Survey. In comparison to other trusts, the trust scored about the same for 43 questions and 'somewhat better than expected' or 'better than expected' for six questions. The survey found that mother's experience could improve the most in the postnatal period, for example: communication, information sharing, care planning and timely discharge from hospital.

Governance

Leaders sometimes operated governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff followed policies to plan and deliver care however we found the escalation policy was last reviewed in 2019 prior to the pandemic and therefore did not consider the changes in practice and pressures faced by staff and the service. Guidelines were reviewed by the risk and governance team and ratified through the maternity assurance group. Staff accessed policies online whenever they needed them.

There were several forums that fed into the trust governance structure, these included the risk committee, the maternity assurance group and the care group board.

Maternity

The groups monitored operations, performance, workforce, reviewed organisational structure, and reviewed updates on the clinical negligence scheme for trusts (CNST) action plans, and Ockenden maternity recommendations. The groups met at regular intervals to review a standing agenda, the national maternity and neonatal reports, maternity dashboard, hospital updates and screening. Group membership included but was not limited to, the chief nursing officer, the care group director, the care group general manager, the obstetrics service line director, director of midwifery, and the head of midwifery.

Leaders attended monthly divisional quality, safety, and governance meetings. Some meetings had a formal agenda and minutes were produced and available to staff throughout the service. The team reviewed serious incident referrals that qualified for a Health Safety Investigation Branch (HSIB) investigation. The trust board reviewed outcomes. The maternity and neonatal trust safety champions had set up bi-monthly meetings that have been minuted since April 2022. There was no set agenda for these meetings; no information was minuted in June 2022 and limited information was minuted in August 2022.

Leaders sometimes liaised with the local maternity voices partnership (MVP) to include them in the attendance invites.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders did not always have access to accurate information in order to effectively manage risk. Leaders ran maternity services using systems that required updating and did not give them access to detailed, relevant and contemporaneous information. The service kept a risk register which contained 34 items at the time of inspection. These were rated using a red-amber-green (RAG) system. Since the inspection the trust showed us that discussions around risk were also documented on their risk reporting system and this system contained more detailed information.

Leaders used a maternity dashboard and performance was monitored monthly via the divisional quality, safety, and governance meetings. The dashboard contained monthly birth statistics and outcome data.

Maternity safety champions met trust-wide on a regular basis from all areas of maternity. The team reviewed the perinatal quality surveillance tool, maternity dashboard, continuity of carer and neonatal care, and there was discussion on the maternity safety board. The service had self-certified as compliant in all 10 areas of the Clinical Negligence Scheme for Trusts (CNST). However, on the day of inspection we found areas that were non-compliant. For example, they had not implemented an effective triage system rooted in reducing risk, mandatory training levels were below the required rate, and auditing on the elements of Saving Babies' Lives care bundle showed that the trust was not meeting the requirements in several areas, including the 'Gap Grow' scanning pathway.

According to the latest National Maternity and Perinatal Audit (NMPA) report, the percentage of babies born at term with a 5-minute Apgar score of less than 7 was higher than expected (1.8% compared to the national mean of 1.1%). The hospital has a level 3 neonatal unit and is the regional centre for transfer of high-risk and pre-term births. The last report was published in June 2022 and was based on births in 2018/19.

In the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) perinatal mortality surveillance report published in October 2021 (based on births in 2019), the stabilised and adjusted perinatal mortality rate at the trust was between 5 and 15% lower than the comparator group average for all births and for births excluding congenital anomalies.

Maternity

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Several results were shared from infection control, record keeping and other audits, and these have been commented on elsewhere in the report.

Information Management

The service collected data and analysed it. Staff could not always find the data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust used paper-based records systems along with some out-of-license IT systems. We found the electronic patients record systems did not always support staff to maintain a contemporaneous care record because it relied on a pressured workforce to enter data and print records in retrospect. This was identified as a significant risk to the service and was on the risk register. The trust had procured an end to end IT system for planned implementation in 2023.

Centralised CTG monitoring was a recommendation in the Ockenden essential immediate actions (2022). Leaders told us that the central monitoring system was planned for installation imminently but did not specify a date. The trust had invested in new CTG machines in June 2022. Staff expressed concerns that the trust was not moving fast enough to address this issue as this feature of care would improve oversight and safety. Since the inspection centralised monitoring was implemented in all clinical areas.

Engagement

Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services.

The maternity voices partnership (MVP) had started to attend meetings with maternity managers and were invited to 'walk the patch' and speak to women about their experiences of maternity services. The non-executive director and the MVP chair told us that liaison between the trust and the MVP needed improving. Work to strengthen the relationship and input from the MVP into oversight processes was being planned.

The MVP chair told us that there were regular meetings with the regional MVP and the transformation midwife, and that relationships with the trust were good. The MVP had provided themes within the feedback from women on their care, which included informed consent, effective communication between clinicians and patients, and personalised care.

The MVP chair told us that there were lots of ideas for the future but that these had not reached the planning or implementation stages at the time of inspection.

Results from the 2021 NHS Staff Survey showed that maternity services had lower levels of staff engagement than in other areas of the trust, and lower levels than the national scores.

Learning, continuous improvement and innovation

Staff were committed to improving services. They did not always have a good understanding of quality improvement methods or the skills to use them. Leaders encouraged innovation and participation in research.

Staff were committed to improvement. The trust had a business cases for improving the bereavement suite offer at the hospital and had looked at provision of a midwife-led unit on site.

Maternity

We spoke to staff on the Day Assessment Unit (DAU) who had identified an area for service improvement, and analysed where services could be streamlined or updated, this included implementation of a standard operating procedure.

The trust had a specialist perineal clinic midwife who had implemented a postnatal clinic for women with obstetric anal sphincter injury (OASI). The service was audited and reported positive outcome data to the maternity assurance group. The specialist midwife lead for the service was assisting in the roll out of similar clinics for other trusts in the region and this was an example of up-to-date practice that responded quickly to best evidence-based guidelines for the benefit of women.

Staff told us that they were encouraged to participate in innovation however there was no allocated time for individuals to do so and extra learning was done in staff's own time.

Outstanding practice

We found the following outstanding practice:

- The trust provided a psychological wellbeing service to staff called SUSTAIN and staff had access to a clinical psychologist as part of this service. The trust has presented on the model at NHS conferences. Staff told us that clinical debriefs and pastoral care was provided to them following any difficult events at work.

Areas for improvement

MUSTS

Core service

- The service must ensure that adequate mitigation of all risks has taken place to cover the immediate period before the completed of implementation of a new end to end maternity IT system. (Regulation 12)
- The service must ensure training is completed and compliant against national and trust targets, including but not limited to emergency evacuation of the birth pool, patient group directive medicine, human factors training, safeguarding, and interpretation of CTG monitoring. Any staff who have not received appropriate training must have adequate mitigation in place. (Regulation 12)
- The trust must ensure safe staffing levels are in place, consider skill mix of the workforce and monitor maternity staffing 'red flags'. (Regulation 18)
- The service must ensure that appropriate risk assessment takes place when women and birthing people are admitted to the service, or when attending triage. (Regulation 12)
- The service must review processes within maternity triage and ensure that care, reviews and waiting times for women are appropriate, risk-based and monitored for efficacy and safety. (Regulation 12)
- The service must ensure adequate standards of documentation is maintained, including but not limited to: CTG monitoring, patient observations, medicine charts and handover of care. The service must ensure that patient records are stored securely at all times. (Regulation 17(2))
- The service must ensure that incidents are raised, processed in a timely manner and categorised and risk rated appropriately in order to learn and improve. (Regulation 12)

- The service must ensure equipment is in-date. (Regulation 12)

SHOULDS

Core service

- The service should ensure that audits against the Saving Babies' Lives Care Bundle v2 are continued and that areas of non-compliance are identified and acted on appropriately in order to improve care.
- The service should review ways in which learning is shared and disseminated in order to reach more staff and improve safety culture.
- The service should review processes for induction of labour, identify ways to alleviate delays and ensure the escalation pathway is used effectively.
- The service should consider reviewing guidelines more frequently in order to maintain contemporaneous with best evidence-based practice.

Our inspection team

The inspection team consisted of a CQC lead inspector, CQC team inspectors, and specialist clinical advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Regulatory Leadership (Secondary and Specialist Healthcare).