Barking, Havering and Redbridge University Hospitals NHS Trust

Queen's Hospital

Inspection report

Rom Valley Way
Romford
RM7 0AG
Tel: 01708435000
www.bhrhospitals.nhs.uk

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Ratings

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

Our findings

Overall summary of services at Queen's Hospital

Requires Improvement 

We carried out this unannounced focused inspection in response to concerns we received about the safety and quality of the maternity services. The concerns related to the governance and culture of the service. As this was a focused inspection our inspection activity focused only on parts of the safe and well led key questions. This means we did not look at all key lines of enquiry in each of the domains.

We inspected maternity care throughout the maternity unit so we could get to the heart of the patient experience. During the inspection, to understand the patient journey and make sure that women and babies were kept safe from harm, we visited: the antenatal clinic, triage, the antenatal ward, the postnatal ward, Coral ward, the high dependency maternity ward, the labour ward and the midwifery led birth centre.

We did not inspect the community midwifery teams because the services were carrying out care within the community and we did not visit community services on this inspection.

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

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

How we carried out the inspection

The team that inspected the service comprised of two CQC inspectors, an obstetrician specialist advisor and a midwifery specialist advisor.

The team spent a day on site at the registered location and carried out a desk top review of data the provider sent following the onsite inspection. We carried out telephone interviews with senior staff in the days following the onsite inspection.

On the day of the inspection we visited: triage; antenatal ward; post-natal ward; Coral ward; the high dependency maternity ward; the labour ward; and the midwifery led birthing centre. We spoke with 22 staff members including: service leads, matrons, midwives, doctors and midwifery care assistants. We looked at six sets of notes, reviewed a wide range of documents including: policies, meeting minutes, action plans, prescription charts, risk assessments and audit results.

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 services went down. We rated them as requires improvement

- Staff did not always complete risk assessments for women and identify women at risk of deterioration and not all women were accurately scored using the Maternity Early Obstetric Warning Scoring designed to recognise women at risk of deterioration.
- The service did not always complete venous thromboprophylaxis (VTE) assessments for women being admitted to the antenatal ward.
- Staff did not routinely refer to the psychological and emotional needs of women during handovers.
- The service did not manage incidents well and lessons learned were not always shared with staff.
- We were not assured consultants always attended to a patient suffering from post-partum haemorrhage and the service did not record consultant attendance.
- Cardiotocography was not always reviewed by a second independent midwife.
- The service did not always use up to date guidance and we found examples of guidance that was out of date.
- Not all staff had received multidisciplinary training at the time of the inspection and the service was projected to be noncompliant by the deadline set by Clinical Negligence Scheme for Trusts.
- Leaders did not always run services well using reliable information systems and support all staff to develop their skills.
- Staff did not always feel respected, supported and valued by the leadership teams.
- Not all risks identified were included on the divisional risk register.

However;

- Staff had training in how to keep people safe and protect women from abuse and staff knew how to refer women for specialist support.
- The service used an assessment tool to triage women calling into the service for advice and support.
- The service had a set criteria for which women would be accepted into different clinical areas to help keep women safe.
- The service managed surgical site infections well and performed above the national average.
- The service had emergency consultant anaesthetist cover 24 hours a day seven days a week.
- We observed staff responding quickly to emergency buzzers being pulled and communicate effectively with other teams.
- The service held multidisciplinary handovers twice a day to discuss patients with staff coming onto shift.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

Maternity

Is the service safe?

Requires Improvement 

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

Safeguarding

Staff had training on how to recognise and report abuse.

Staff received safeguarding adults training and safeguarding children's training. We reviewed training data and found as of April 2021, all eligible staff had received training in safeguarding adults' level one and 98.91% of eligible staff had received safeguarding adults' level two. There were three levels of safeguarding children training. All levels showed above 95% of eligible staff had received training and safeguarding children level three was at 100%. The training data was not broken down by every staff group or grade and data did not show which staff required what training and to what level. However, there was evidence of staff compliance with training.

The deputy named midwife for safeguarding told us they were developing plans to increase staff attendance at supervision sessions.

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and well maintained. Cleaning records demonstrated that all areas were cleaned regularly. We reviewed five cleaning audits and found all areas had achieved above 95% as outlined in the operational service plan.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Patients and visitors were subject to COVID-19 screening at the entrance to the hospital and information displayed showing what PPE precautions patients and visitors should take.

Most staff followed infection control principles including the use of personal protective equipment (PPE). All staff on the maternity wards we observed during the inspection wore a surgical mask in line with national guidance for COVID-19 and hand sanitiser was readily available for staff, patients and visitors to use. However, we observed three members of staff who were not 'bare below the elbow'. This was not in line with nationally recognised guidance set out by National Institute for Health and Care Excellence (NICE) and posed a risk of cross infection.

The service carried out audits to assess infection control across the maternity unit. We reviewed the joint divisional infection prevention and control audit tool which listed an expected standard for the service to meet. Following the audit an action plan was sent to each area audited with action to take and a compliance score. We reviewed five action plans, one for each area of the maternity unit and found; two areas were compliant, two were partially compliant and

one was non-compliant. The area shown as non-compliant had nine areas of concern identified which included: staff wearing long sleeve gowns in clinical areas. An action plan was developed in response. The service provided data for a one-month period for each area, so we were not able to see if any themes had been identified or improvements had been made.

Incident forms were completed for women suffering with an infection and when women and babies were readmitted to the service. Data provided by the trust showed between January 2021 and June 2021 there were 50 incidents recorded due to infection. Following the inspection, the trust told us they reviewed incidents forms between April 2021 and June 2021 and found seven women and two babies were readmitted and treated for signs of an infection but none of the patients developed sepsis.

The service reported they had a system in place to report mandatory surveillance data to Public Health England. Between May 2020 and June 2021, they reported no cases hospital acquired of MRSA and Clostridium difficile (C.diff) within the maternity service.

The service carried out an audit of surgical site infections (SSI). We reviewed the surgical site infection review and found between January 2020 to December 2020 42 SSI were identified out of 796 patients. This was 5.2% SSI rate which was better than the national average of 5.3%.

The maternity quality of care board was used to display audit results in all clinical areas we visited. In the morning of the onsite inspection data displayed on this board for MRSA and hand hygiene was recorded as not applicable and the rationale for this was unclear. Staff could not see how the maternity service had performed in these audits and if improvements needed to be made. However, in the afternoon data for April 2021 was added to the board showing hand hygiene compliance of 89.5% on the antenatal ward and 94.3% on the postnatal ward. Service leaders told us IPC audits were temporarily paused in November 2019 due to staff shortages and were reinstated in May 2020. However, this was before the COVID-19 pandemic, and it was not clear why the data was not available for display on the quality of care board.

Environment and equipment

The design of facilities, premises and equipment mostly kept people safe.

Access to the maternity wards was via intercom or a swipe card and staff screened visitors to each ward before they were granted access. This prevented unauthorised access to the clinical areas.

All maternity wards except the birth centre were located on the same floor providing easy access for staff and when transferring women between clinical areas. The birth centre was located on a different floor and access to the labour ward, if required, was via a lift. This had been identified as a risk and added to the risk register in November 2020. Associated risks included: a six-minute transfer time between the birth centre and the labour ward; lift failure; and delays in accessing a working lift. In April 2021 a standard operating procedure was approved for use to mitigate against these known risks. This included a process for staff to follow in the event all lifts were out of action. The risk register identified staff practice in emergency drills as a control measure. The service carried out emergency skills and drills on 9 and 21 December 2020 and leaders told us further training was planned for August 2021. Following our inspection, the trust reviewed their incident reporting system and found there had been no incidents recorded relating to a patient transfer from the birthing centre to the labour ward since 2017.

The birth centre had a fire evacuation plan, which included pictures of the evacuation, equipment to move women but there was no consideration for the evacuation of babies. The trust told us the senior nurse was responsible for moving those at risk first and direct all other patients to a place of safety. Babies were deemed to be included these categories. However, there were no specific instructions for the transfer of babies if they were not co-located with their mother or the mother was unable to hold the baby during evacuation.

Staff carried safety checks of specialist equipment. The four resuscitation trolleys we checked during the inspection had all been checked weekly by breaking the seal to check equipment inside and an exterior check of the trolley was carried out twice a day. These checks ensured equipment was available when required in an emergency.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman or take action to remove or minimise risks. However, we observed staff act quickly upon women deteriorating.

Women were seen by a midwife within 30 minutes of arrival most of the time. We reviewed the audit of care within 30 minutes and one hour which showed in 11 of the last 13 months over 90% of women were seen by a midwife within 30 minutes and the service had consistently achieved this target since October 2020. Between April 2020 and January 2021, the percentage of women seem by medical staff within one hour was below 86% dropping as low at 71% in April 2020. However, since February 2021 the service had improved and were consistently scoring above 89% of women.

The service carried out a venous thromboprophylaxis (VTE) risk assessment for all women booking into the service. We reviewed the Venous Thromboprophylaxis (VTE) risk assessment audit 2021 which reviewed 70 spot checks of women's notes between November 2019 and January 2021. This audit found that 100% of women had a VTE assessment at the point of booking although, one woman was incorrectly scored. The trust told us that in an audit that took place between November 2019 and January 2021, 23 of 26 women admitted to the antenatal ward did not have a VTE assessment carried out and 19 did not have TED stockings prescribed. This is not in line with the Royal College of Obstetricians and Gynaecologists which states risk assessments should be repeated if a woman is admitted to hospital, intrapartum and postpartum However, the trust also told us following the inspection, that since that audit, actions had been put in place to improve compliance. At the time of the inspection, 100% of 6 sets of notes we reviewed had a VTE assessment completed. For week ending 06/06/2021 compliance on the antenatal ward was 100% (67 patents).

The service was not always compliant with the modified World Health Organisation (WHO) maternity checklist. Data provided for April and May 2021 showed that of 138 women who went to theatre, 14 women had a partial or non-compliant WHO Checklist. We reviewed the minutes from the April 2021 labour ward forum and found that the April WHO checklist data was discussed, and this meeting had an MDT attendance.

Monthly spot checks were carried out to review theatre swab counts. The April and May 2021 audits showed that instruments and swabs were reviewed by two professionals 100% of the time.

Staff did not always use a nationally recognised tool appropriately to identify women at risk of deterioration and escalate them appropriately. The Maternity Early Obstetric Warning Scoring (MEOWS) system was in place and staff received training in its use during their induction. However, the May 2021 MEOWS audit found only five of the 10 notes audited had been accurately scored. We noted an action plan had been developed to address these concerns but had not been fully implemented at the time of our inspection. Following our inspection, the trust sent data showing improvements had been made. In June 2021 16 records were spot checked, all accurately recorded physiological parameters however, three women did not have the correct score and in July 2021 5 women of 28 did not have the correct score.

Maternity

To ensure the specific needs of women on the HDU were met the consultant obstetrician and consultant anaesthetist reviewed women together. We noted when other teams such as the surgical team were requested to review women this was undertaken promptly. However, not all women's chart included evidence of MEOWS observations being taken or a score to alert staff of any deterioration, therefore staff may not have access to all information to inform their review.

To promote safe care and effective management, the maternity service had a set-criteria by which women were assessed and accepted into each clinical area. This made sure women were cared for in the most suitable clinical setting. Risk assessments were carried out for women wishing to use the midwifery birthing unit.

Staff completed psychosocial assessments for vulnerable women but not all women had evidence in their records that a mental health assessment, using a recognised tool or that possible domestic abuse had been explored. Following the inspection, the provider told us this information was recorded on the electronic medical record to help keep women safe. We reviewed the maternity dashboard for June 2021 and found it was reported 96.3% of women in June were asked about domestic violence at booking. Senior leaders told us some appointments had moved to virtual appointments during the COVID-19 pandemic. This meant that staff did not ask women about domestic violence concerns during virtual appointments for their safety. Women were asked about domestic violence at the face to face appointment.

Staff in the antenatal clinic we spoke with were aware of how to refer women for additional support and how to escalate concerns and access specialist midwives, for example to the mental health team via referral and a substance misuse midwife.

We observed the cardiotocography (CTG) midwife attend the labour ward handover and review all CTGs. We saw that buddies were assigned for 'fresh eyes' reviews and 'fresh eyes' being completed and reviewed electronically. 'Fresh eyes' is recommended by national guidance to ensure CTGs had been correctly interpreted and escalated if appropriate. However, spot checks showed that not all CTGs were reviewed by a second independent midwife. We requested audits of CTG and 'fresh eyes' reviews. The trust sent us the central monitoring log for April 2021. This demonstrated that 15% of women's notes checked for 'fresh eyes' had not been completed. There were 23 cases where 'fresh eyes' was not performed and 20 did not document the reason why this was missed. To address this the trust planned to continue to spot check 40 women's notes monthly and discuss the importance of fresh eyes at handover times. Following the inspection senior leaders told us they had introduced an end of shift reconciliation to be included at handover where staff would explain and document why 'fresh eyes' had not taken place. Further data analysis provided by the trust showed fresh eyes was compliant 96.8% of the time when broken down by possible hours in the month.

Shift changes and handovers did not always include all necessary key information to keep women and babies safe. For example, at a handover we attended, information relating to a high-risk woman was not discussed and there was no discussion about women with additional needs, for example whose first language was not English and required an interpreter. Following the inspection, the trust told us, once the main handover was completed, there was a further detailed midwife-to-midwife bedside handover which covered all the details of care including her risk factors and well-being in detail. There was also a separate coordinator-to-coordinator handover that covered these issues for each patient.

We observed staff respond to emergency situations effectively in the birth centre. The team responded quickly and there was effective communication with the labour ward resulting in the woman being appropriately assessed. We also

observed staff effectively managing the care of a deteriorating woman, whose care was escalated and the additional support of obstetricians, midwives and HDU nurses obtained. However, there was no agreed plan of care post this event and staff did not follow a situation, background, assessment, recommendation (SBAR) type handover when transferring her to the HDU. This meant vital information may not have been shared and used to inform her on-going care.

Staff told us consultants were not always called to attend women suffering from postpartum haemorrhage when cases reach 1500ml blood loss and guidance did not have a clear process to follow if a woman suffered blood loss in the birth centre. The divisional director told us an issue with the guidance had been identified and this was reissued on 31 March 2021. We reviewed this guidance and found there were clear instructions when to call for assistance and a process to follow for staff in the birth centre. However, it did not state which members of medical staff needed to attend and the trust did not audit consultant attendance. We found the dates at the beginning of the guidance showed it was approved on 21 October 2019 and issued 1 November 2019. In the footer of the page it showed it was issued 31 March 2021. This meant it might not be clear for all staff which was the most up to date version. However, the guidance included a table of amendments further in the document, which was dated and clearly showed what had been updated.

At the time of the inspection the maternity service was compliant with two elements of Saving Babies' Lives Care Bundle Version 2 (SBLCB2) and partially compliant with three elements. This is a care bundle brings together best practice and aims to reduce perinatal mortality. We reviewed the SBLCB2 progress report for May 2021. This demonstrated the service was partially compliant with three of five elements at the time of our inspection. Senior leaders told us they expected to meet the compliance dates of 30 June and 30 July 2021 in the action plan; however, at the time of the inspection we could not evidence this. Following the inspection, the service provided evidence that these actions had been met however it was too early to assess whether good practice had been embedded.

The service had a COVID-19 action plan which was developed using nationally recognised guidance, for example from the Royal College of Midwives. There were 15 action points, 11 of which the service was showing as compliant. At the time of our inspection, the remining four were undergoing audits to provide the service with assurance they were compliant.

All women who called the unit were triaged using an assessment tool, the findings of this assessment were recorded on a standard form and provided a record of the advice given, such as for the mother to come into hospital.

Midwife staffing

The service did not always have the planned number of maternity staff with the right qualifications, skills, training and experience on shift to keep women safe and to provide the right care and treatment.

The service did not always have the planned number of nursing and midwifery staff on shift to care for women and babies. Staffing levels were displayed on the wards we visited showing planned number and the actual number of staff. At the time of the inspection senior staff told us there were midwife vacancies at band five and six. Data provided showed this equated to a 7% vacancy rate. Several other members of staff in key positions stated they were leaving the trust. We were told that over the last 12 months the service had a consistent vacancy rate and that to address this there was a rolling recruitment programme in place. Discussions took place during handover and at the daily maternity safety huddle on the movement of staff and how best to allocate resources taking into consideration the acuity of women. Staff used the incident reporting system to report staffing issues. In the last 12 months 219 incidents were reported relating to maternity staff levels, 168 of these reporting a lack of suitable midwives in and out of hours.

Maternity

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The work force planning report dated December 2020 used the acuity tool and national guidance to assess the level of staffing required by assessing the number of deliveries and case mix using clinical indicators.

The number of midwives and nurses did not always match the planned numbers. The service used bank midwives to supplement its permanent workforce and relied on supernumerary staff working clinically. Matrons we talked with told us they were asked to work 50% of their time clinically but this was difficult to achieve with other work pressures. However, following the inspection, the trust told us only the two deputy matrons were expected to work 50% of their time clinically, but this was not the case for other matrons, as three of the five matrons worked clinically one day per week (20%). This arrangement had been suspended since 1 April 2021 at the request of the Head of Midwifery. Data for the period May 2020 to April 2021 showed between 6-11% of staff working in the maternity service were bank staff. The use of bank staff contributed to the service achieving 88% of its planned staff levels, but unfilled shifts by bank were consistently high. For example, in May 2021 all areas had between 10-18% of bank shifts unfilled. The data provided did not reflect supernumerary staff working clinically such as ward managers and deputy matrons. This was reflective of the national picture during the COVID-19 pandemic with staff shortages due to sickness and shielding.

Senior staff acknowledged that staffing numbers did not always meet planned numbers. However, due to the decrease in the number of births they were able to maintain the funded 1:26 ratio. Data provided post our inspection confirmed that the number of births had reduced, and this had been a continuing trend over the last six months. Based on reduced number of births the midwife to birth ratio was between 1:23 and 1:26. The ratio recommended by Safer Childbirth, based on the expected national birth rate, is 28 births to one WTE midwife for hospital births.

On the day of our inspection the skill mix did not meet the planned skill mix. The HDU did not have a midwife or nursery nurse allocated as planned and was staffed by registered nurses, who were not dual trained as midwives, with support from a nursery nurse who was working across two wards. This issue was not addressed at the maternity safety huddle and the HDU did not have a midwife as planned.

The ward manager could adjust staffing levels daily according to the needs of women. Staff were redeployed between wards depending upon the acuity of the women they were caring for. We observed a midwife being redeployed from the birthing centre to the postnatal ward where they did not have the planned number of midwives.

The service sickness rates were consistently higher that the trust target of 3%. Data provided by the trust showed two peaks in December 2020 and January 2021, which reflected national peaks during the COVID-19 pandemic. At the time of inspection short- and long-term sickness rates were 5.61%.

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.

The service had enough medical staff to keep women and babies safe. The divisional director told us there were two gaps in the consultant rota filled by locum staff they were hoping would become substantive and very few gaps in the other medical staff rotas. Data provided by the trust showed two gaps in the consultant rota were covered by internal locums, five gaps in the registrar rota and two gaps in the junior doctor rota were covered by a mix of internal locum and agency staff.

Maternity

Medical staff numbers matched the planned number. The medical staffing numbers had been amended during the peak of the COVID-19 pandemic with staff redeployed across the hospital to support their peers. This redeployment had resulted in December 2020 and January 2021 of a fill rate of under 94%. However, since February 2021 the fill rate for medical shifts has been above 99%.

The service had a consultant anaesthetist available 24 hours a day seven days a week as part of the emergency obstetric service. The divisional manager told us there was a resident consultant anaesthetist presence for the emergency obstetric service from 08:00 to midnight seven days a week and non-resident consultant cover from midnight to 08:00. Additionally, there was support 24 hours a day seven days a week from a registrar anaesthetist and supernumerary cover from junior doctors. Following the inspection, the trust sent the obstetric anaesthetic on call rota for the week beginning 26 July 2021 and we found there were no gaps.

The service had very low turnover rates for medical staff. Between September 2020 and May 2021, the turnover rate was 0%. We requested data for staff absence, data provided showed in May 2021 there was an absence rate of 5%. This was not broken down by staff group and it was not clear the number of medical staff who were absent.

Records

Staff kept records of women's care and treatment. Records were mostly clear, up to date, stored securely and easily available to all staff providing care.

A combination of paper based, and electronic records were maintained for each woman that reflected the care and treatment they had received. All records were easily accessible and stored securely with paper records held in a locked trolley.

Staff we talked with on the postnatal ward told us women were given a personal child health record, often known as the 'red book', for each baby and staff made sure this was included with their discharge notes.

All records we reviewed were signed and dated. They included individual specific information such as the woman's body mass index, if they had vitamin D prescribed and if they had had their COVID vaccination. However, they did not include evidence that CTG records had 'fresh eyes' documented, which demonstrated not all CTGs had been reviewed by a second staff member. They also lacked evidence that women had been asked about possible domestic abuse. Staff told us following the inspection that information was recorded on electronic records all staff had access to. Domestic abuse was not recorded in paper notes to help keep women safe.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. All prescription charts we reviewed were legible, named, dated, allergies and weight were clearly documented, the route of administration and time and date it was administered were also clearly recorded.

Fridges used to store medication had records to demonstrate temperature checks had been completed and that these were within the expected ranges.

Controlled drugs were stored securely in locked cabinets in a locked room. The keys to the cabinet were held by the ward manager or midwife in charge. The controlled drugs book had daily checks recorded. Staff we spoke with were aware of how and to whom to escalate concerns if the daily check showed a discrepancy.

Maternity

Incidents

The service did not manage safety incidents well.

Most staff knew how to report incidents and felt confident to do so. The incident and serious incident policy was in date, reflected national guidance and was due to be reviewed February 2023.

The trust had an incident and serious incident policy which included how to manage duty of candour. We reviewed this policy and found it states duty of candour should be applied when there has been a notifiable incident. The March 2021 staff newsletter risky business reminded staff to complete an incident form for all postpartum blood loss and evoke duty of candour. Data sent following our inspection showed that duty of candour had been applied 87 times between June 2020 and June 2021. However, a senior member of staff told us duty of candour was only applied to serious incidents which was not in line with the trust's incident and serious incident policy. Following the inspection, we reviewed a random sample of 10 incidents and found that duty of candour had been evoked for all incidents.

The maternity department had a backlog of incidents to review, there was an action plan to address this backlog supported by a task and finish group. At the time of our inspection data provided demonstrated that the back log had reduced from 479 incidents in March 2021 to 171 in May 2021. These remaining incidents were to be managed using the service's incident investigation systems and processes. Following our inspection, the service submitted the overdue maternity incident paper presented to the maternity assurance board on 5 July 2021 which showed the number of open incidents pre-2021, excluding incidents with an ongoing root cause analysis (RCA), had been reduced to 13 and there were 38 open incidents pre-May 2021.

Improvements have been made to the system that logs incidents. The incident system did not allow the responsible person to be easily identified as the incident was sent to a large group of people. Following the inspection, the provider told us the system was amended in February 2021, following a pilot, to clearly identify the person responsible. The service told us a new weekly report had been created to identify incidents that had been open for more than 10 days. This prompted the lead investigator to review and take action before it was overdue. This report was shared with the divisional and corporate teams for oversight of incident management. However, we had limited assurance that systems would be effective in continuing to manage the ongoing review of incidents. Staff told us they felt unsupported reviewing incidents and often worked outside of working hours to review them. We were told key members of staff responsible for this work were leaving the trust and at the time of our inspection had not been replaced.

The maternity significant incident group (MSIG), a multidisciplinary group, reviewed incidents bi-weekly. The outcome of the meeting was a completed proforma and the meeting was not minuted. We reviewed five proformas and found they did not all include learning, had limited information recorded and one 'red incident' did not include actions to take. It did not include documentation to capture discussions showing why incidents were rated as red and how it was decided an incident required further investigation. Following the inspection, the service provided an updated template they would use going forward to include the outcome of the assessment, and reason a decision was arrived at.

Senior staff expressed concerns the criteria in the trust serious incident policy was not consistently applied to rate incidents including what was a serious incident and there was a high threshold for declaring a serious incident. They felt incidents were easily dismissed and the level of investigation did not always reflect the severity of incidents. Staff responsible for implementing actions identified in action plans developed post an incident investigation were not always fully briefed on why the action was required this resulted in a lack of knowledge and understanding about the action and what was required.

Maternity

There was limited learning from incidents. Staff we spoke with were unable to give examples of learning from incidents. For example, staff told us there had been seven born before arrivals (BBAs) in May 2021 but were unable to identify any learning from these incidents. The staff newsletter we reviewed provided feedback on incidents, however the copy available on the ward was from March 2021 and staff told us they hadn't received a newsletter for April 2021. Following the inspection, the trust told us the newsletter was circulated with learning updates which sometime led to delay. For example, updates for March 2021 were circulated in May 2021."

Some staff reported being able to escalate issues, clinically and operationally but not all staff felt raising concerns would lead to action being taken. We found there was a divide between staff up to band six and band seven and above. Staff we talked with up to band six told us managers were supportive and encouraged staff to report incidents.

Managers debriefed and supported staff after any serious incident. The divisional director told us they provided support to staff following an incident. A debrief was held the following day and they would approach staff periodically to check on them.

Is the service effective?

Inspected but not rated

Our rating of effective stayed the same. We did not re-rate effective as we did not find a breach of regulation in this domain at this inspection.

Evidence-based care and treatment

The service did not always use up to date guidance and we found examples of guidance that was out of date.

Staff knew how to access policies and guidance on the trust intranet and did not print these to reduce the risk of an out of date policy being used to plan care. However, staff did not always have up-to-date guidelines to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed the maternity guidance log and found that 10 guidelines were out of date, one by more than 200 days and three had not been allocated a named reviewer. There were 12 guidelines logged as review required and three of these did not have an allocated member of staff to review them. The risk of out of date policies was not included on the maternity risk register. Following the inspection service leaders told us in April 2020 the trust acknowledged policies and guidance review dates may lapse due to the ongoing pandemic and all documents on the intranet would be deemed as current. The service provided an update that showed since our inspection, five of the 10 guidelines had been reviewed, updated and ratified and the remaining five were at different stages of being signed off ready for use.

The trust had a policy on how updates to policies and guidance should be managed. However, the maternity service did not always follow this policy and key professionals were not always involved in the review or consulted when policies were updated. For example, the pharmacist was not consulted or involved in the sign off the hypertension policy. This resulted in incorrect information being included and published before the error was identified. This policy had not been republished at the time of our inspection.

Senior staff told us some guidance was contradictory and caused confusion for staff. An investigation into a serious incident identified confusion when a woman would have a scan when smoking had been identified as a risk factor. We reviewed the growth assessment protocol and Obstetric ultrasound protocol and found it listed risks and rated them as minor or major. The protocol indicated a trigger for serial growth scans when one major risk was identified and three or more minor risks. This protocol had been in place since January 2018.

At handover meetings we attended, staff did not routinely refer to the psychological and emotional needs of women, their relatives and carers. The handover sheets for 33 women we reviewed only two referred to the psychological and emotional needs. Following our inspection, the trust carried out an audit of 71 postnatal women between 25 June and 6 July 2021. This showed that 34 women did not routinely refer to the psychological and emotional needs of women. The trust advised us the audit was being analysed and an action plan would follow.

Competent staff

The service made sure staff were competent for their roles and Personal Performance Reviews had been introduced to conduct a performance and wellbeing review for all staff.

The service operated a six-month rotation programme to allow midwives to rotate throughout the service to develop their skills and experience in all areas. This programme was positively evaluated by staff as it assisted staff to maintain their skills.

Managers made sure staff received any specialist training for their role. However, during the pandemic face to face training sessions had been put on hold with virtual Practical Obstetric Multi-Professional Training (PROMPT) sessions being provided in line with guidance from Royal College of Obstetricians and Gynaecologists. The education team had raised concerns about user ability and operability in relation to these virtual sessions via the education team's exemption report submitted to the maternity quality safety group. It was unclear what if any action had been taken to address these concerns, but the issue was discussed at the divisional board meeting.

The maternity service was not compliant with Clinical Negligence Scheme for Trusts (CNST) safety action 8. This requires services to be compliant with PROMPT (training that covers the management of a range of obstetric emergency situations). In line with NHS Resolution, the 90% target and date for compliance had been removed and providers were advised to address any shortfall as soon as possible. At the time of the inspection the service had gaps in compliance. As of 28 May 2021, three of six staff groups had attained 90% compliance. Anaesthetists had the lowest compliance rate of 29%. Based on numbers booked to attend training, anaesthetists and maternity care assistants (MCA), were projected to be noncompliant by the deadline. We reviewed the mandatory training emergencies training plan, there were ongoing actions to help the service achieve compliance, for instance there was a plan to hold MDT faculty meetings to review compliance figures and monthly reports to be sent to maternity quality and safety. The expected completion date for these actions was after the inspection.

During the inspection we were told PROMPT training often takes place at the weekend and consultants are not remunerated for attending but there were plans to review consultant job plans to reflect training needs. However, following the inspection, the trust told us PROMPT training was only delivered during the week and fetal surveillance training was sometime delivered at the weekend

Not all of the band 7 midwives had completed neonatal life support training (NLS). Five of the 12 band 7 midwives were yet to complete this training. This risk was on the risk register and there were plans to deliver training to all band 7 midwives with a target date of September 2021.

Maternity

At the time of inspection data we reviewed for April 2021 showed only 54.37% of all maternity staff had completed mandatory newborn basic resuscitation training which was a significant drop from 84.06% in September 2020. The trust provided data post inspection that showed that 94% had completed this training by 1 June 2021. Data showed that that there were sufficient numbers of staff who had completed this training on each shift. The current NLS trained band 7 midwives assessed staff competency face to face including how they undertake to provide immediate neonatal resuscitation.

Staff appraisals were paused during the COVID-19 pandemic. In March 2021 58.72% of staff had received an appraisal, however this was below the service target. Following the inspection, senior leaders told us the trust had introduced 'My conversation' in 2021/2022, which replaced the Personal Performance Reviews (PPRs). 'My conversation', focussed on the wellbeing and development of the employee, not on their performance. Leaders told us this outlined staff should have a minimum of two conversations a year to help improve performance. The trust set a target that all staff should have their first conversation by the end of August 2021. Maternity leaders told us they were on target to achieve this, but this evidence of this was not available at the time of our inspection.

Some staff were able to access further training and development and were supported by their managers to do so. Those staff we spoke with told us they had been encouraged to attend further training to develop their careers with some being provided with time out from their clinical roles to complete this. However, other staff members told us they felt their careers would not progress further in this service and were disappointed by the lack of support from senior leaders.

Managers provided supervision drop-in sessions, but some staff told us these were not always well attended, due to clinical commitments. Staff told us this this poor attendance had been flagged to the matron to encourage attendance. Following the inspection, the provider told us the lead midwife for safeguarding had developed a plan to ensure compliance with safeguarding supervision. Between April and June 2021, the service achieved 31% which is within the agreed trajectory as requested by the CCG.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women most of the time. They supported each other to provide good care.

The service had introduced the labour ward multidisciplinary handover standard operating procedure (SOP) in June 2021. This outlined who was expected to attend MDT handovers and the order of topics to be discussed followed by ward round. The SOP included a proforma to be competed at each MDT handover and a sign in sheet. At the time of the inspection the SOP had been recently introduced and there was insufficient data to audit its effectiveness.

The service held multidisciplinary team (MDT) handovers twice a day to discuss patients and improve their care. We noted that all members of the team contributed to discussions and women requiring urgent reviews were flagged and plans made to involve and consult with other professionals not in attendance were made. However, the ward round was not currently an MDT ward round. The divisional director told us this was under review and the lead obstetric anaesthetist was working on ways to improve this.

The weekly CTG huddle had MDT attendance. A review of the attendance of this meeting demonstrated that midwifes and medical staff of all levels attended.

The midwifery staff we spoke with reported good working relationships with their medical colleagues. Several of the consultants and senior midwifery staff had offices on the unit this arrangement promoted MDT working, easy access to advice and support.

Maternity

Seven-day services

Most key services were available seven days a week to support timely care.

The labour ward had at least one consultant available from 08:30 to 00:00 Monday to Friday and 08:30 to 20:00 at the weekend. The divisional director told us this would be reviewed in line with recommendations from the Ockendon report published in December 2020. Women are reviewed by consultants depending on the care pathway. Other medical staff were available in the hospital 24 hours a day. Staff we spoke with reported easy access and a timely response from the medical staff.

Consultants led daily ward rounds on all wards, including at weekends. However, staff told us consultant led night-time ward rounds were not consistent on a Saturday and Sunday which was a recommendation in the Ockenden report which states ward rounds should be consultant led twice a day seven days a week.

Is the service well-led?

Requires Improvement ↓

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

Leadership

Leaders within the service were not always effective in implementing meaningful changes that improved safety.

The maternity service formed part of the women's and children's health division in the trust. The senior leadership triumvirate for maternity consisted of the divisional director, divisional manager and director of midwifery. A non-executive director had recently been appointed as the lead for maternity. Due to the pandemic, they had had little involvement with the department to date.

The senior management team understood the challenges of the service and were aware of the cultural and operational issues that needed to be addressed and the improvements that were needed. They stated that they had plans to improve the service including introducing additional roles. However, key staff including the Head of Midwifery were leaving the trust and it was recognised that until these posts would be vacant until they were recruited to. The trust had a plan in place to cover these positions. For example, an interim Head of Midwifery was appointed until a substantive appointment was made.

The director of midwifery co-chaired the local maternity system (LMS) for north east London which brings together people involved in providing maternity care locally.

Not all staff felt supported by the senior leadership team. Some staff said they felt supported by leaders while others reported an unsupportive environment with senior leaders threatening staff with performance management.

There was reported to be a lack of communication between senior leaders and managers. Managers were not always involved in improving the service, with action plans being developed by the triumvirate team without input from managers who stated they were not aware of action plans in place to address specific concerns and felt side lined. The recent staff survey demonstrated that communication was ineffective, with 43% of maternity staff reporting that communication between senior management and staff was effective. However, this was higher than the trust wide score

of 39%. This lack of communication between the two groups was evidenced in the maternity champions meeting, which stated staff had not been communicated with regarding workstreams and kept informed of changes. However, the trust had taken action to address this and an action was assigned to find a minute taker to attend the meeting so notes could be taken.

We were not assured there were effective working relationships between consultants and members of the senior leadership team within the service. Medical staff told us there was a disconnect between the consultant group and divisional director. A meeting to resolve and improve working relationships was held in September 2020. However, staff told us this meeting was not minuted, did not resolve issues, and there were no outcomes. Following the inspection senior leaders told us a record of the meeting and action points were emailed to all attendees however, we did not see evidence of this email.

Medical staffing had mixed views regarding support from the senior leadership team. One staff member said there was a split in the consultant body between those that felt supported and those that didn't. Another said there was a huge discrepancy in consultant workload. One said the senior leadership team blamed consultants and do not involve them in consultation regarding changes to the service. However, following the inspection, the provider told us the divisional triumvirate included all parties within discussions about service changes via the leads for the service. They told us members of all disciplines were present at the maternity quality and safety meeting, where these issues were discussed. There was an open invite to all staff to attend any of the meetings. We reviewed the 2020 staff survey which showed 17% of medical staff felt communication between senior management and staff was effective and 17% felt senior managers would act on staff feedback.

The staff survey found that 91% of midwifery staff knew who the senior managers were, which was higher than the organisational figure of 83%. The director of midwifery had their office on the unit and some staff told us this meant she was accessible and visible and could speak to her directly.

The Director of Midwifery held monthly meetings with maternity safety champions. These meetings were consistently attended by staff and actions assigned. The Director of Midwifery also held monthly meetings for maternity unit staff. The meeting was split in to two separate sessions according to grade so staff could feel free to talk. However, we were not provided evidence of topics raised or action taken.

Culture

Not all staff felt respected, supported and valued. The service did not always have an open culture where staff could raise concerns without fear.

During our inspection several members of staff raised concerns regarding poor culture and bullying and that the senior leadership team did not seem to listen to staff. Some staff in different roles and grades told us they did not feel supported and respected in their roles. Staff told us the leadership team were aware of the cultural issues but did not challenge individuals or hold them accountable for poor attitudes and behaviours. Other staff stated that this was a longstanding issue and the leadership team had recently started to take action.

Not all staff felt able to raise concerns and those staff who did raise concerns told us they did not always receive feedback or understand why their concerns had not been responded to and actioned. One senior member of staff told us they had to work around the triumvirate in order to affect change.

The service received poor feedback from trainee doctors in October 2020. A survey conducted by trainee doctors was presented to the trust educational department which was raised to the medical director and divisional director. The

concerns raised were about the behaviours of some consultants towards trainees and each other. The divisional director arranged individualised coaching program for each consultant to address concerns raised by trainees and an external review was commissioned to provide one on one coaching sessions with staff. Due to the ongoing pandemic this work had been delayed and commenced the week of this inspection. Staff we talked with had a coaching session booked but as this work was ongoing, at the time of our inspection we were unable to evaluate whether this had been effective.

The service had requested support from the organisational psychologist. The divisional director told us they had requested this support to assist with cultural issues within the consultant body and to help develop a plan to overcome the cultural issues. The service had recently appointed an obstetric lead and it was hoped this role would help improve the culture within the medical team.

Staff told us there was a division between the midwifery leadership. Staff we talked with told us they did not always feel supported by all leaders and that there was support for one side or the other. Mediation had been requested between staff and senior leaders. This was being escalated to human resources at the time of the inspection. Due to staff leaving the trust, some staff told us they did not know who their line manager would be and how the service would remain safe which left them feeling anxious and unsupported.

The service leadership did not always include senior staff in discussions about improvements to the service. Senior staff told us they were not included in the development of an action plan following issues raised in the service or discussion on other areas of concern such as issues with the consultant body. They told us there was a danger action plans did not involve staff at all levels which might lead to staff being disengaged with planned improvements to the service. Divisional leaders told us some plans were not shared outside the triumvirate to protect the identity of those raising concerns.

Some members of staff told us that threats of performance management and verbal warnings were used creating a culture of anxiety and mistrust. Staff told us they had been told their jobs were at risk in meetings which made it a difficult environment to work in**.**

Midwifery staff told us they had a good working relationship with medical colleagues. Midwifery staff felt able to escalate patients when needed and could access support and advice.

The service had a maternity voices partnership (MVP) which is an NHS working group independently chaired to help develop local maternity care. The two co-chairs were appointed during the ongoing pandemic and as a result have only been able to visit the service once. They told us they had good working relationships with staff and were beginning to connect with users of the service via social media platforms. Senior staff told us they valued the role of the MVP and their help in capturing the voice of users of the service. Due to the ongoing pandemic, the trust had not carried out the annual friends and family test to gather feedback from patients about the service.

The trust had a freedom to speak up guardian (FtSU) in post which is a role giving independent support and advice to staff who want to raise concerns. Representatives from FtSU told us there had been an improvement in engagement with the trust over the last five months and they had been able to support and assist people to raise concerns in the maternity service to the deputy chief executive officer who was working to support teams.

Governance

Leaders did not always operate effective governance processes, throughout the service. Not all staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Maternity

The governance structure provided to us was a midwifery structure showing job titles and a reporting line to the director of midwifery (DoM). This did not reflect the structure at the time of our inspection. We reviewed the meeting structure and found there were three monthly meetings held in maternity. The divisional board had a set agenda and terms of reference for the meeting. Senior staff told us divisional quality meeting reported to the quality assurance committee which reported to the trust board and the director of midwifery reported to the board quarterly.

The governance structure divided responsibility between the maternity quality and safety manager, who led on governance and the head of midwifery who line managed matrons; both of whom were line managed by the DoM. However, we were told, this arrangement resulted in matrons not feeling involved in the governance process.

Senior leaders told us a review of the governance structure was planned and changes would be made. This included an external review of governance process but at the time of the inspection we were told there was no timeline for when this review would take place. Following the inspection, the trust told us this review was trust wide and completed on 24 June 2021. Changes already implemented included the recently appointed clinical lead for obstetrics and the creation of additional posts to support the management of governance processes. For example, a project manager who would have oversight of all ongoing action plans would be recruited.

Not all action plans we were told about appeared on the action plan log. We reviewed the action plan log and found it had 10 action plans listed. This did not include action plans staff told us about, for example an action plan to improve the governance of the service and the continuity of care action plan.

Meeting minutes and action logs were not always dated correctly. The women and child health divisional quality and safety group minutes sent included two dated 15 March 2021. One set of these minutes included ratification of minutes from March 2021 and included updates for April 2021 and therefore had not been dated correctly. We reviewed the last three action logs for this meeting and found that, action logs were not clearly dated. The date was in the footer of the page which did not always correspond with the updates on actions. There were two action logs for March 2021 one of which had April 2021 updates. The action log for February 2021 was dated February 2020. This may lead to confusion and there was a risk staff would not always review information relating to the right month.

We reviewed the attendance at the divisional board and women and child health divisional quality and safety group. We found that both meetings had an MDT attendance to include all areas of the division and service.

The triumvirate meetings were not minuted. We asked to review the minutes and were provided with a photo of handwritten notes in a notebook. The notes did not record attendance and were a paragraph long. We were not assured that issues were fully discussed, and action taken to address concerns. Following the inspection, the trust told us this was an informal meeting and minutes were not taken. Decisions were made at the divisional board meeting that met formally once a month and were minuted.

The divisional director told us there is a weekly meeting with the consultants to discuss learning. This was an informal meeting to improve communication and was not minuted. A formal meeting was held monthly. We reviewed the minutes and found there was good attendance.

We reviewed the minutes from the maternity champions meeting. It was identified that minutes from the quality and safety meeting were not shared to disseminate information to staff as the minutes were predominantly action points as there was not a proper minute taker. However, the trust told us staff received updates in different ways including a weekly safety brief and staff newsletter Risky Business. We reviewed the newsletter from January to April 2021 and found quality and safety issues were presented.

Maternity

We reviewed the women and child health maternity quality and safety group minutes from March 2021. This identified issues for escalation to the divisional board meeting. We reviewed the action the minutes from the March 2021 divisional board meetings and found these issues were escalated in the exception report presented.

Management of risk, issues and performance

Leaders and teams had systems to manage performance, but this was not always effective. They did not always identify risks and issues or identify actions to reduce their impact.

The service had a risk register in place which identified risks to the service; however, not all risks had controls in place and not all identified risks were included. The risk register included risks rated as low, moderate, high but none were considered to be extreme for the maternity service. We noted three new risks for obstetrics had been added in May 2021 with one rated as high but the controls for this risk were reported to have started in March 2021. It was unclear why it had taken several months for this risk to be added to the risk register. The 'risk cause' was a gap in staffing between July 2020 and October 2020. The risk did not have an action plan and controls in place, and it was not clear who had oversight of actions required to close this risk.

The senior leadership team were able to tell us what they considered to be the top risks to the service; however, this did not reflect three of the top four risks on the risk register for maternity and obstetrics.

Not all risks identified during the inspection, and those the senior leadership team were aware of, were included on the risk register. The risk register included risk associated with hypertension guidelines being out of date but other out of date guidance was not include on the risk register. At the time of the inspection 10 pieces of guidance were out of date and 12 required a review according to the maternity guidance log. Therefore, we were not assured that there were controls in place to mitigate any risk.

The service had an annual audit programme with each audit having an identified lead auditor and a date of presentation. The programme included audits of nationally recognised standards such as saving babies lives care bundle 2, Birmingham symptom specific obstetric system (BSOTS) and audits of care provided to women. All audits were scheduled to be presented after the date of our inspection.

A postpartum haemorrhage (PPH) audit review group was established in February 2021, we requested copies of the PPH audits, this information was not provided and a summary of the 10 meetings held so far was submitted. The summary concluded consultant attendance at a PPH was overall acceptable but found there was a lack of escalation to a consultant out of hours potentially placing women at risk. We were unable to confirm these audit outcomes as the documents requested were not provided.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff accurately score women using the Maternity Early Obstetric Warning Scoring designed to recognise women at risk of deterioration. (Regulations 12 (2)(a)(b))
- The trust must ensure staff share all necessary information at handovers and that staff follow a situation, background, assessment, recommendation (SBAR) type handover. (Regulations 12 (2)(b))
- The trust must ensure that the holistic needs of women are consistently considered during handover. (Regulations 12 (2)(b))

Maternity

- The trust must ensure all guidelines and policies are up to date. (Regulations 17(2)(f))
- The trust must ensure effective systems are in place to ensure incidents are managed within the 20 days trust target. (Regulations 17(2)(f))
- The trust must ensure the risk register accurately reflects the risks to the service. (Regulations 17 (2)(f))

Action the provider SHOULD take to improve

- The trust should ensure that data on the quality of care board is recorded and up to date.
- The trust should ensure fire evacuation plans specifically mention babies, and babies are referenced in drills and skills training performed by staff.
- The trust should review the latest guidance from the Royal College of Obstetricians and Gynaecologists issued in June 2021, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology, to ensure post-partum haemorrhage guidance reflects latest updates.
- The trust should consider taking minutes to record triumvirate meetings, actions and outcomes.
- The trust should ensure minutes and guidelines are correctly dated.
- The trust should ensure that thromboprophylaxis (VTE) assessment are carried out at each stage of the maternity pathway to help keep women them safe.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, an obstetrician specialist advisor and a midwifery specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance