Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Inspection report

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Date of inspection visit: 27 May 2021
Date of publication: 02/09/2021

Ratings

Overall rating for this service

Inspected but not rated

Our findings

Overall summary of services at John Radcliffe Hospital

Inspected but not rated

We carried out this unannounced, focused safety inspection, of maternity services provided by the trust. This was because we received information of concern about the safety and quality of the service.

We received information of concern from a whistle-blower (WB), in January 2021. They raised concerns about the culture in maternity services. We held focus groups in March 2021 to explore any issues further. We received another four WBs following the focus groups.

Concerns were related to the culture and included concerns about:

- Bullying.
- Hierarchy.
- Dysfunctional teams.

We also asked the trust to send an anonymous staff survey to give all maternity staff the opportunity to share their experience of working at OUH and raise and share concerns in a safe and confidential manner. The survey deadline was Friday 11th June. The anonymous results have been used as evidence to support our report.

This inspection has not changed the ratings of the location overall. However, our rating of maternity services went down. We rated them as requires improvement. See the Maternity section for what we found.

How we carried out the inspection

Our inspection was unannounced, (staff did not know we were coming). This was to enable us to observe routine activities in maternity services. We carried out a focused inspection related to the concerns raised. This does not include all of our key lines of enquiry (KLOEs). We looked at KLOEs specific to the domains: safe, effective and well-led.

We visited the delivery suite, the postnatal ward and the co-located midwifery led unit at the main maternity unit at the John Radcliffe. We also visited the Cotswold Birth Centre and the Horton Midwifery Led Unit. We spoke with 48 staff, including service leads, midwives (bands 5-8) obstetric staff (junior-consultant), consultant anaesthetist, obstetric theatre staff, maternity care support workers, student midwives and the newborn hearing screener. We conducted an anonymous survey of maternity staff.

We joined the Intrapartum Shared Learning Meeting and the Board Safety Champion Meeting. We observed the morning multidisciplinary handover on the delivery suite, the morning safety huddle on the delivery suite and the elective caesarean section pre-list briefing.

We reviewed 10 sets of maternity records and 10 prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, grading of recently reported incidents and audit results. Before our inspection, we reviewed performance information about this service.

Our findings

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 maternity services went down. We rated them as requires improvement because:

- The environment meant staff could not always respect women's privacy and dignity.
- The service did not always assure themselves that they maintained a clean environment.
- Staff did not always assess risks to women.
- They did not always manage medicines well.
- We received mixed feedback regarding the culture. Some staff did not always feel respected, supported and valued.
- Managers did not always monitor the effectiveness of the service through local audit, and they did not always have effective governance processes.

However:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. They were focused on the needs of women receiving care. Staff were generally clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills to all staff, and they generally made sure staff completed it.

Staff received and kept up-to-date with their mandatory training. We asked the trust what impact COVID-19 had on training schedules and were told that all face-to-face training had been changed to virtual training. Most staff had kept up to date with their mandatory training during the last year. This was against a trust target of 85%. Mandatory training included but was not limited to: fire safety, information governance, equality, diversity and human rights. Compliance with training and competencies in CTG (electronic monitoring of baby's heart rate) for June 2021 were a minimum of 95%.

Maternity

Virtual practical obstetric multi-professional training (PROMPT), was provided during the pandemic. This was led by anaesthetic staff and delivered to multi-disciplinary staff groups. Compliance rates for all staff groups in June 2021 were a minimum of 94%.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse, and they knew how to apply it.

There was a dedicated maternity safeguarding team. Team members were trained to safeguarding level 4. Each team member covered one geographical area of the service. Safeguarding staff received supervision and support in their role. Staff had access to support with safeguarding matters.

The safeguarding team worked closely with the social work and mental health teams. There were daily meetings with the hospital social worker and monthly with the mental health team. Access to the social worker, mental health and health visitor records further supported the midwives in gathering information and conducting reviews. Community midwives who were based at GP surgeries could also check women's GP records. This gave them access to additional information about a woman's history. The multidisciplinary meetings and sharing of information helped to ensure they interacted and coordinated their efforts to diagnose, treat and plan for vulnerable women and families.

To help keep women safe, safeguarding concerns were recorded in the electronic records as an alert. This was only accessed by staff and not shared in women's handheld notes. Midwives assessed women's vulnerability at the booking appointment. They used a scoring process based on a woman's health and social history. If there were concerns the safeguarding team was alerted. They tracked the women and monitored who was involved in supporting them. Birth plans were recorded by 34 weeks and stored electronically. This ensured relevant staff had access to necessary information, and outcomes were monitored.

There was a specific pathway for children who were under 18 years of age. The pathway helped staff to identify signs of child sexual exploitation. The Lotus Team provided continuity of care to some of Oxford's most vulnerable women. This was part of their national strategy to address health inequalities across maternity services and improve outcomes for all mothers and babies.

There was a confidential service providing support to women and girls who had undergone female genital mutilation. This was run by a team of female doctors experienced in women's health. Women could self-refer or be referred by heath care professionals. They offered a wide range of care and support including psychological support and counselling.

There had been a pause in role specific safeguarding training during the COVID 19 pandemic. This had resulted in a short fall in attaining the trust's training target of 85% compliance. Only 73.4% had completed safeguards adults' level 2 training and only 61.9% had completed safeguarding children level 1 training. Only 76% of staff had completed safeguarding level 2 and 3 and only 67% of staff had completed basic training in preventing radicalisation. This was monitored at local and trust board level and a plan to return to full compliance with trust targets was in place.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Most areas were visibly clean, but they did not always keep equipment visibly clean. Cleaning records were not always up-to-date, and records did not demonstrate that all areas were cleaned regularly.

Maternity

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained. However, equipment was not always clean and stored safely. The clinical and non-clinical areas such as equipment rooms and computer rooms on the delivery suite, postnatal ward and midwifery led unit at the John Radcliffe hospital appeared clean and dust free. At the Cotswold birth centre, equipment such as the birthing balls, were stored on the floor and were dusty. A cleaner attended every morning, and thereafter, the policy was for staff to clean rooms and equipment after use.

Staff were unable to provide copies of completed cleaning checklists. Cleaning audit results, for maternity services for February-May 2021, varied between 76% to 100% and there were no results submitted on 25/60 occasions. Staff were not always complying with their infection prevention and control policy for cleaning standards, to keep mothers and babies safe.

Staff followed infection control principles in the use of personal protective equipment (PPE). Staff used the right level of PPE. Hand sanitiser gels were available throughout the service. Staff were bare below the elbow and staff washed their hands appropriately.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe, but did not always ensure their privacy and dignity was maintained. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of women and their families safely, but the design of the environment did not always follow national guidance. All labour rooms were single rooms. At the John Radcliffe Hospital the service had access to three obstetric theatres and a recovery area. The neonatal unit was close by if a baby's condition deteriorated and required an urgent transfer.

The unit had a dedicated suite for women who went into labour before 24 weeks of pregnancy. This was located on the midwifery led unit on level 7. After 24 weeks of pregnancy, women who had a bereavement laboured and gave birth on the delivery suite. There was no dedicated bereavement room or suite, away from celebrating families and the sound of live babies. There was one en-suite room on the delivery suite which would be offered. There was no signal on the door to indicate the mother had experienced a loss. The rooms were not decorated in a sensitive way and were not soundproofed. This meant women could hear babies cry and celebrating families. Women who had a bereavement would not receive care and support in an environment considered to be most conducive to meet their needs.

Women's privacy and dignity was not always maintained. There was no signage to indicate when rooms were engaged. Staff did not use privacy curtains in the labour rooms on the Horton midwifery led unit. The doors were opposite the birthing beds and women's' privacy and dignity could not always be maintained. A lack of en-suite facilities for labour rooms meant women had to walk down the corridor to access facilities. Women's privacy and dignity was not always protected when in labour and during birth.

This environment did not fully comply with Department of Health guidance: Children, young people and maternity services Health Building Note 09-02: Maternity care facilities. The environment on the delivery suite and the birth centres were not homely and welcoming. They were not decorated in a sensitive way. They were clinical, and included bare walls, stark lighting and no home from home approach.

Maternity

There was open access between the midwifery assessment unit and the delivery suite. This meant there was a potential baby abduction risk. The trust had assessed and mitigated the risk with plans for further controls to be put in place. The maternity unit was a secured building with further secure compartments within the building, However, we did not see any evidence that baby abduction was practised as part of their emergency skills and drills to help manage the security for mothers and babies.

The service had enough suitable equipment to help them to safely care for women and babies. Twelve pieces of equipment on the delivery suite had evidence of up-to-date safety testing. Records demonstrated staff carried out daily safety checks of specialist equipment. Consumables at the Horton MLU were stored securely and were all in date. Aromatherapy oils were stored securely in a locked cupboard.

However, these were not always safely managed. The sepsis bags contained out of date blood culture bottles and culture swabs. We highlighted this to staff, and they removed them immediately. The adult resuscitation trolley and checklist at the Horton MLU demonstrated it was checked daily. However, the tamper evident seal was broken. We highlighted this to staff, but they did not attend to our concern. Processes were not always being followed to ensure equipment was safe and ready for use.

It was unclear how all staff were assured equipment was maintained and safe to use in all areas. We reviewed the baby scales, an ultrasound monitor, and a blood pressure monitor at the Horton MLU. It was not possible to tell when they were last safety checked, calibrated or serviced. Staff were unaware where such information would be available. The trust later provided us with information which demonstrated equipment was maintained, calibrated and safety checks performed. It remained unclear how staff were made aware of this, and assured the equipment was safe for use to support safe care for mothers and babies.

The John Radcliffe had six infant resuscitaires for 12 labour/birth rooms. They were kept in the labour ward corridor. They also had two which were stored in their obstetric theatres. We asked the trust how there were assured they had a safe ratio of infant resuscitaires to labour rooms. Senior staff confirmed the number of available resuscitaires had never been a cause for concern and the trust considered they were able to provide a safe service with the number available.

Equipment was provided to assist staff with the safe removal of a woman from the birthing pool in an emergency. The service provided training in how to use the equipment. The trust policy Water in Labour and Birth Guideline V2.3 31/03/2021 indicated the ideal number of staff to support the evacuation was five. However, the technique could be adapted when five were not available. There was also a video available which demonstrated this.

However, staff were unfamiliar with the procedure and policy at one birth centre. Staff were also unfamiliar with where the equipment was stored. A pool evacuation could be delayed in an emergency and the mother's safety compromised.

Staff disposed of clinical waste safely. Staff managed clinical waste well. Waste was segregated with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Arrangements for control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman, and take action to remove or minimise risks.

Maternity

We reviewed 10 maternity care records. The lead professional was not named in any of them. It was not clear whether the women were assessed as being on a high or low risk pathway. This meant that women might not be allocated to the correct pathway which meant the correct staff might not be involved in leading and planning their care.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. However, they did not always complete it. Of the 10 MEOWS charts we reviewed, only three were fully completed. There was a risk deterioration would not be identified in a timely way. This meant prompt action may not be taken.

Only four out of ten women were asked about domestic abuse on two occasions, and four out of ten women were never asked. The trust could not be assured that midwives were always identifying women in abusive relationships in order to support them and their unborn baby to stay safe.

Information provided by the service demonstrated transfer times from community settings could take up to an hour in an emergency. There was an agreement with the local ambulance service to try and ensure such requests were given the right level of priority. Staff told us they discussed place of birth with all women in pregnancy and this was reviewed in full at 36 weeks of pregnancy. Staff said discussions included the potential time for a transfer in an emergency or for non-emergency situation. They also provided a specific information leaflet, but they did not mention how long transfers could take. The service did not monitor that the conversations about potential transfer times took place. This meant the service could not be assured women had received the information in order to make an informed decision about their place of birth.

Safety huddles took place in each ward or area and included all necessary information to keep women and babies safe. There was an overview of antenatal women who were in-patients. Some safeguarding issues were highlighted which could be clinically relevant. The midwife in charge shared safeguarding and birth plans and was able to handover events from previous days. The handover also included a discussion about high-risk women. Staff were encouraged to contribute, and there was effective communication and shared learning.

Safety huddles took place at 9am and 4pm on the delivery suite. The times were recently changed to accommodate the neonatal staff. All midwifery staff were encouraged to attend. We were told they were generally only attended by labour ward staff and the bleep holder. The safety huddle was attended by the bleep holder, labour ward matron, labour ward coordinators, consultant on call, consultant anaesthetist, theatre staff and neonatal staff. MDT meetings and safety huddles were completed in accordance with NHS Improvement- Implementing handovers and huddles: a framework for practice in maternity units March 2019.

They also used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication between team members.

The service used the Birmingham Symptom Specific Obstetric System (BSOTS). This included the completion of a standard clinical triage assessment. The assessment was completed by a midwife, within 15 minutes of a woman's attendance. This helped to define clinical urgency, guide timing of subsequent assessment and immediate care.

Staff completed screening for specific issues. Carbon monoxide screening, which was part of 'saving babies lives 2016' initiative, was performed in each set of notes reviewed. Staff risk assessed every woman's risk of venous thromboembolism at booking, on arrival in labour, and during post-natal care. This was in line with national guidance. They monitored the baby's growth and accurately plotted this. Staff identified babies that were not meeting their growth potential, as they would be at higher risk of complications.

Staff discussed the importance of all pregnant women supplementing their diet with vitamin D. Risk assessments took account of vulnerabilities such as ethnicity and living in areas of social deprivation. There was a lower threshold to review, admit and consider multidisciplinary escalation for women from a black and ethnic minority background.

Staff advised women to be aware of their baby's individual pattern of movements after 28+weeks of pregnancy. They used an information leaflet to support these discussions. This could be accessed in multiple languages via the trust website. Women were informed about the importance of monitoring their baby's movements and what to do if they had concerns.

Midwifery staffing

The service had enough maternity staff with the right qualifications to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service used a recognised staffing acuity tool to determine the total midwifery time required to care for women and used the evidence from their monitoring to support the recruitment of additional band 7 midwives. This was based on a minimum standard of providing one-to-one midwifery care throughout established labour.

The labour ward coordinator was always supernumerary. The supernumerary status of the coordinator was monitored as part of the quality dashboard. Data showed the coordinator was supernumerary on all shifts from November 2020-March 2021. This was in line with the 'Safer Childbirth' recommendations, (October 2007), which state: 'every labour ward must have a rota of experienced senior midwives as shift coordinators, supernumerary to the staffing numbers required for one-to-one care'.

Managers accurately calculated and reviewed the number and grade of midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. This included midwives dedicated to the triage area. Senior leaders described how they mitigated risk when staffing did not meet acuity levels. Leaders explained the service escalation process which was detailed in their escalation policy. The policy detailed the minimum number of midwives needed on the ward areas and that escalation should go through the services supernumerary bleep holder. They would redeploy midwives not engaged in clinical duties to ensure cover.

Managers told us maternity staffing levels were discussed at all safety huddles, which was supported by the records we saw, and the meetings we attended. Additional safety huddles were called as required. The director of midwifery attended the safety huddle if an escalation occurred.

Safe staffing in maternity was regularly reported to the quarterly public trust board meeting. The trust had completed a successful recruitment campaign and most new starters were in post by December 2020. The services midwife to birth ratio had been an average of 1:24.9. This was a significant improvement in comparison to the same period in 2020 when the ratio was 1:27.8. They had an effective system of workforce planning to ensure safe staffing levels.

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.

Maternity

The service had enough medical staff to keep women and babies safe**.** This included two senior house officers, a junior registrar, senior registrar and two consultants for daytime hours. During night-time hours the maternity service was supported by a junior house office and two to three registrars. A consultant was on call from 9.30pm- 8am.

The service always had a consultant on call during evenings and weekends. The cover provided by consultants was aligned to labour ward. Obstetric consultants did not cover gynaecology. The consultant rota for the months of March, April and May 2021 showed consultant cover every evening, night and over every weekend.

Consultants were on site from 8am to 9.30pm, seven days a week, although they stayed if there was high acuity on the delivery suite. They completed two delivery suite rounds, one in the morning and one in the evening. The service was adhering to recommendations outlined in Safer Childbirth (2007), and Standards in Maternity Care (2016), by providing appropriately trained individuals for the provision of safe intrapartum care. Information provided by the trust indicated there was 109 hour of prospective consultant hours on delivery suite against a target of more than 98 hours.

Trust policy was for consultants to be in attendance within 30 minutes of being called. However, the service did not monitor the length of time it took for the on-call consultant to arrive once called. A Consultant told us they would call a colleague (who lived nearer), if the on-call consultant was delayed due to heavy traffic. They gave an example of when this had happened.

Junior doctors told us there were lots of training opportunities with daily online teaching during the pandemic. They felt well supported and described clinical leaders as ‘very good’ with good senior presence.

Records

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

Staff kept records of women’s care and treatment. The maternity service used mostly paper-based records. Some electronic records, such as prescription charts, were also in use. We checked 10 sets of maternity notes. They were all dated, timed and signed. They all had electronic prescriptions. These included details of the mother’s weight and allergies.

Potential safeguarding issues could be flagged electronically so all clinicians could recognise and act on safeguarding concerns.

Women transferring to the unit from elsewhere had different care records which could not be easily transferred. As a result, midwives would have to re-book women. The trust was in the process of procuring a new digital system to create an end-to-end pathway for maternal health.

Medicines

The service used systems and processes to safely prescribe and administer medicines. However, they were not always safely stored. Staff did not always store and manage medicines in line with the provider’s policy.

We found that not all medicines were stored securely. There were three injections found in unsecure locations. This was addressed when we escalated the issues. Intravenous fluids were stored in locked cupboards at the birth centres. A box containing drugs to manage hypoglycaemia at the Horton MLU, was checked. All medicine was in date and the box was stored in a locked cupboard.

Staff kept records of medicine fridge temperatures and ambient room temperatures of their medicine rooms on the delivery suite and postnatal ward. Staff told us there were frequent breaches in room temperatures. This was a known problem and was captured on the risk register. This meant the service was non-compliant with statutory medicine storage requirements. The cause was listed as the average room temperature being consistently above the acceptable temperature range because of a lack of ventilation to the room. Staff were unable to control the room temperature, as they were not able to isolate the heating and the air conditioning was not working. The trust had attempted to mitigate this risk by asking estates for advice and quotes for fitting an air conditioning unit.

There was no dedicated maternity pharmacist. This was recorded on their risk register. The trust had attempted to mitigate this risk by using an existing pharmacist to help with clinically vulnerable women. Post inspection the trust informed us a there was a 0.5 WTE maternity pharmacist in post with an additional 0.5 WTE resourced through bank staff.

Records for checking controlled drugs demonstrated that the Medicines Policy was not always followed. There were gaps in the records when two staff had not checked the stock in line with the policy. The process for maintaining safe checks was not effective.

We were not assured that medicines supplied following a Patient Group Directive (PGD) were managed properly by clinical staff. The guidelines seen at the Cotswold Birth Centre were past the review date, and although an updated policy was later provided, we had no assurance that staff were accessing the updated policy. Midwives told us they could offer women sterile water injections for backpain in labour. They also told us they had not received training to complete this.

At the Horton MLU there was an 'eclampsia box'. This contained emergency medicines to manage women with eclampsia. Eclampsia is considered a complication of pre-eclampsia and this condition can be life threatening. As women with pre-eclampsia and eclampsia would not be cared for at a MLU it as unclear why the box was present. Staff thought it was probably left from when it had been a consultant led unit, two years previously. There was a potential risk of unsafe use of these medicines.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well ventilated areas, away from heat and light sources, in an area that is not used to store any other flammable materials.

The maternity service used an online prescribing and administration system for maternal prescriptions. We reviewed the medicine records for eight women and found prescriptions were legible, named, dated, allergies and weight were clearly documented, and administration and route of administration were also clearly recorded.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team.

Staff knew what incidents to report and how to report them. The trust used an electronic reporting system which all grades of staff had access to. They had a list of maternity triggers. This was a list of examples that staff should report as an incident. For example, incidents involving a drug error or a breach in confidentiality. Staff were reminded that the list was not exhaustive, and everyone had a responsibility to report all incidents that they felt could affect safety.

They held a maternity safety team meeting at 8am every day. This was followed by a daily incident reporting meeting to review all incidents from the previous day or night. The maternity clinical governance committee (MCGC) met monthly.

Maternity

This was chaired by the obstetric lead for maternity safety. The group agreed how to disseminate the learning from incidents to all staff. This could be through training days and updates, via a 'top tips' section in staff bulletins, general email communication, team meetings or 'at a glance' posters. Themes from incidents were shared using the staff update board on the delivery suite. It also included reminders about key changes to guidance or practise.

Staff gave examples of how they were supported through debriefs following a serious incident. There had been a recent serious incident and the on-call manager, director of midwifery and consultant neonatologist had attended during night hours to support staff. Mangers told us de-briefs and follow up support included a mixture of formal and informal support. For example, staff were given a choice of a professional midwifery advocate, an independent counsellor/ psychologist or hospital Chaplin.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

A large number of guidelines had passed their review date. The service had a process to prioritise them, but managers did not always ensure staff followed current guidelines.

Fifty-one of out of 133 current policies were past their review date. They were stored on the trust electronic system, The quality assurance and improvement team managed the update of guidance. This was being monitored by the maternity clinical governance group and terms of reference for a document review group had been agreed. Clinical guidelines were prioritised, then the most out of date, followed by the most regularly used. They told us it could be challenging to find suitable authors to update guidelines, as they did not have protected time for this work. As a result, staff might not always have access to the most up to date guidance and policies to guide their practise.

Staff in some areas referred to paper copies of guidance that were not the most current. Staff told us they sometimes used paper versions as some computer systems could be slow. Trust policy was to not to use paper versions, except controlled versions in an emergency. Staff were not always complying with the policy and some staff were not always using the most current version of a policy or guidance.

The service had conducted a limited number of audits during the last year. This was because some were deemed non-essential during the COVID-19 pandemic. The essential audits that were completed, related to compliance with NICE guidelines. An audit plan for this year was being developed and reflected the national and trust wide audit requirements. More local initiated audits were still to be considered. Audit results and action plans were discussed and shared to drive improvement.

Patient Outcomes

Staff monitored the effectiveness of care and treatment, and they used the findings to make improvement and achieve good outcomes for women.

Maternity

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service used monitoring results to improve safety. These indicators were scrutinised at monthly maternity clinical governance meetings and provided assurance at the executive-led quality committees and trust board quality committee. Immediate safety concerns would be highlighted through the daily safety huddles, incident management and professional escalation.

The service participated in relevant national clinical audits. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Competent staff

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.

All Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers supported staff to attend team meetings and forums to share specific learning. For example, the 'Women's Intrapartum Group Meeting'. Staff were supported to present cases they had been involved with and there was an emphasis on learning, not blame. Managers made sure staff had access to notes when they could not attend meetings. Staff updates were shared through emails notifications and maternity bulletins. The bulletins had been shared weekly until April 2021 when they became monthly. Steps were taken to ensure staff were kept informed.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Several staff told us of developmental opportunities that had been encouraged and supported. For example, the director of midwifery had supported two of the midwifery managers to complete a course to help prepare them for a head of midwifery role. Other midwives had been given additional training and support for specialist roles, such as the diabetic specialist midwife post.

Managers supported midwives and support workers to develop through yearly, constructive appraisals of their work. They attended courses and secondment opportunities following appraisals and 1-1 meetings with managers. This included courses such as advanced neonatal life support training and examination of the newborn and infant physical examination programme. Requests to work in different areas such as moving from the community to the delivery suite were supported. Women were cared for by staff who were supported in their role.

Managers made sure staff received any specialist training for their role. Staff completed specialist training in order to work in high dependency care, the safeguarding team had been trained to safeguarding level 4 and some labour ward coordinators had completed advanced training in neonatal life support. Staff had the skills and knowledge to work in specialists' areas.

Managers identified poor staff performance promptly and supported staff to improve. Health Safety Investigation Branch (HSIB) recommendations showed staff were not always interpreting, classifying or escalating cardiotocography (CTG), appropriately. The service developed an in-house CTG training programme for midwifery and obstetric staff which included a competency assessment to continue practising. Remedial one to one training was offered to any staff who failed the test (post training).

Clinical educators supported the learning and development needs of staff. The practice development team (PDT) were a re-established team. Their remit was expanding from a focus on mandatory training to developing knowledge and clinical skills during practice. Practise educators based in the clinical environment helped to facilitate this. The PDT had recently completed a train the trainer course in recognition of the acutely ill and deteriorating patient (RAID). Staff were supported to maintain and develop their skills and knowledge through access to practical based training. Junior doctors told us the clinical educators supported their learning and development needs.

Members of the PDT joined safety huddles and daily maternity incident meetings to help them to incorporate any required learning from complaints and incidents into training, to ensure the learning was shared and embedded into practice.

However, managers did not always ensure new staff had a full induction tailored to their role before they started work. Some staff received a comprehensive induction with clearly identified support and supervision to achieve specific knowledge and skills, whilst others reported receiving a poor handover when they stepped into secondment/new roles, leaving them under prepared, impacting on their ability to perform effectively.

Multidisciplinary working

Midwives, obstetricians and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and babies and improve their care. An intrapartum shared learning meeting took place each Wednesday. This had evolved from the services CTG meeting. The purpose was to share learning from all cases, rather than to focus on those with poor outcomes. This was to remove the 'blame' element that could be associated with only discussing cases where there had been a poor outcome.

The cases were selected to ensure specific learning points and ensure themes could be shared. Rising caesarean section rates, the importance of swab counts, and shared decision making were some of the issues discussed during the meeting in April 2021. Following this meeting a decision was made to review and implement a ward round charter and podcasts to support staff with caring conversations. Informal feedback about the meetings had been very positive. Staff also told us the meetings were supportive and there was an emphasis on learning and positive working relationships.

Women who chose to give birth outside of guidelines were supported. They were offered an appointment with a consultant obstetrician, followed by an appointment with a consultant midwife. The consultant midwife discussed the woman's decision and agreed a birth plan. The aim was to support their choice and ensure everything was planned to ensure the birth was as safe as possible. The consultant midwives were on call to support the primary midwife attending the birth. Midwives told us the teams worked together well to support informed choice. Midwives felt well informed and well supported in these situations. Women were supported by staff following an agreed plan to birth as safely as possible.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. Discussion with staff and a review of rotas confirmed consultant cover was provided, planned ward rounds were undertaken and consultants attended out of hours when required.

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Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. There was a variety of information and support displayed in all the areas

Staff assessed each woman's health throughout pregnancy and provided support for any individual needs to live a healthier lifestyle. This included the importance of taking vitamin D supplementation during pregnancy and the benefits of breastfeeding.

Is the service caring?

Is the service responsive?

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 the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

The senior leadership team (SLT) was formed of a director of midwifery (DoM), divisional (clinical) director and general manager. The DoM had been in post since October 2019. There was a clearly defined management and leadership structure in place. We observed, and were told of, joint working between leaders both within the department, the rest of the trust and with external agencies and bodies to maximise care provision for women and babies.

The DoM was line manged by the divisional director and was professionally accountable to the chief nursing officer. They were supported in their role by two deputy heads of midwifery (HoM). The deputy HoM for community and public health was in a secondment position. The service was recruiting to a substantive post. The deputy HoM for acute maternity and specialist services was recently appointed in February 2021. They had been supported to take part in a director of midwifery development programme. The team was also supported by a clinical governance manager, three consultant midwives (two WTE substantive roles and one WTE developmental role), four clinical midwifery managers and band seven lead midwives. Some of these appointments were recent and the roles were new and yet to be fully embedded.

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The DoM had reviewed the midwifery structure when they joined the organisation. They had restructured to ensure there was a deputy HoM for the acute services and the community services. They had also restructured the practice development team. The aim of this was to ensure more equity with the development of clinical skills and knowledge for community services.

The trust's chief nursing officer was the executive lead and there was a non- executive director with responsibility for the maternity service. In line with 'Spotlight for Maternity' (2016) the maternity services were invited to report directly to the board. Monthly maternity performance indicators formed part of the trusts integrated performance report which was reviewed by the board and or the executive team. The director of midwifery was invited to attend board meetings which raised the profile of maternity services to support the board in understanding issues such as capital constraints and the impact on service developments/improvements.

The trust ensured the trust grade doctors who were part of the middle specialist doctor rotas were also able to gain training equivalent to the specialist trainee doctors in formal training posts. They had a named and funded 'Certificate of Eligibility for Specialist Registration (CESR) champion' to support them like an educational supervisor. Trust doctors had been successful in obtaining training certification at the General Medical Council (GMC), through the CESR route, and others had recently applied to the GMC for CESR accreditation having completed their training.

Vision and Strategy

The service did not have a documented vision for what it wanted to achieve, or a strategy to turn it into action.

There was a trust wide strategy delivering Compassionate Excellence Our strategy for 2020 to 2025. The framework was founded on the trusts vision and values and organised around three strategic objectives -Our People; Our Patients; Our Populations. The Nurses, Midwives and Allied Health Professionals strategy 2021 to 2026 strategy was aligned with the trust overarching strategy. We asked if there was a vison or strategy for maternity services which would support the delivery of this service for the trust. We were informed the trust's overarching strategy for Nursing , Midwifery and Allied Health Professionals Strategy outlined the strategic intent for maternity services.

Culture

Most staff felt respected, supported and valued at a local level. Staff were focused on the needs of women receiving care. The service generally had an open culture where women, their families and staff could raise concerns without fear.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Most staff told us they were proud to work for the trust.

Staff described healthy working relationships at local levels where they felt respected and able to raise concerns without fear. We were given several examples of how staff had felt able and supported to professionally challenge clinical decisions. This included junior members of staff. Staff mostly told us the culture was one of learning, not blame. Staff were women focused and many staff described their immediate teams as 'feeling like family'.

Most staff felt they were encouraged to be open and honest with service users and staff when things went wrong, although some staff did not feel safe to report concerns without fear of what would happen as a result.

Staff were aware there was a Freedom to Speak up Guardian (FTSuG) All NHS trusts are required to nominate FTSUG. Their role was to support staff who wished to speak up about a concern or issue. They ensured any issue raised was listened to and the feedback was provided to them on any actions or inactions because of them raising an issue. We did not ask how many enquiries the FTSuG had received in relation to maternity services but we were assured the trust instigates FTSuG investigations when concerns are raised.

Generally, staff felt the organisation did provide them with effective support to do their job to the best of their ability. They were satisfied with the support they received from their immediate manager. However, some staff felt communication between senior management and staff was not always effective.

Governance

Leaders operated governance processes throughout the service and with most partner organisations. However, these were not all fully effective. 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 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. There was a team, whose prime responsibility was to support clinical governance, who reported to the clinical director and the director of midwifery. The roles covered included obstetric clinical governance and a lead for quality. The maternity clinical governance manager was supported by a perinatal risk coordinator, quality assurance and improvement midwife, digital midwife and an administrator. Each person had a defined role and were in general clear about what was expected of them. Although staff expressed concerns about the size of their workload and responsibilities and how it was a struggle to complete work in their agreed allocated time.

There were clearly defined reporting avenues. The maternity service was part of the surgery, women's and oncology division. Service governance meetings, where incidents, risks, performance, guidelines, audits and user experience were discussed, fed into divisional meetings which then escalated to trust wide committees through to the subcommittees of the board. However, these did not capture concerns relating to out-of-date policies and protocols. The maternity service held joint monthly perinatal morbidity and mortality meetings with the children's service. There was good multidisciplinary attendance and a reporting process. This supported escalation of risks and concerns.

Information was captured and mostly used to monitor the quality of the service provided. The maternity dashboard captured information on workforce, maternity morbidity, perinatal morbidity and mortality, readmissions, maternity safety, test endorsement and public health data. This information was reviewed at the maternity clinical governance meetings. Some information was also presented in the trust integrated performance report. This was reviewed by the board and executive team. Specific maternity papers relating to national schemes and reports such as the maternity incentive scheme and Ockenden report were presented to the board. A maternity-user story had also recently been presented to the board. Staff were able to access information to help them form a judgment about the quality of the service.

The governance of the transfer service provided under agreement with an ambulance provider was unclear. While some information was captured a review of meeting minutes did not provide any indication as to how this information was used. Post inspection the service informed us they reported this information to the clinical commissioning group on a quarterly basis as part of the quality information report.

Management of risk, issues and performance

Leaders and teams generally used systems to manage performance. They identified and escalated most relevant risks and issues and identified actions to reduce their impact.

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included. The risk register included information relating to some of the risks we identified such as the temperatures in the medicine storage areas and the lack of dedicated pharmacist. It did not refer to the number of policies and procedures past their review date.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings. However, we did not see the dashboard shared with staff and the public in clinical areas.

There was a systematic programme of clinical and internal audit covering national and trust wide requirements. However, the complete audit plan for the services for the year had not been finalised.

While performance data was captured and reviewed this did not cover all areas of potential risk. Transfer times from community settings were not collected in their entirety. It was unclear how and when this information was interrogated or used to monitor impact on outcomes. It was unclear how this information was used to monitor the service provided by the local ambulance service to the trust.

The service was engaging with Healthcare Safety Investigation Branch (HSIB), through quarterly safety meetings. They ensured they actioned HSIB recommendations. However, their processes to manage performance were not always effective. Staff were not always referring to the most current guidance or policies. Staff could provide care which did not reflect current national guidance.

Information Management

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

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs.

The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Managers told us they collected data to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. While this was used in planning a women’s individual care needs, managers said the use of this information to inform decisions around service delivery and performance monitoring was in its early stages.

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Engagement

Leaders and staff actively and openly engaged with women and families, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and families.

There were systems in place to engage with staff. The senior leadership team (SLT) told us the wellbeing of all staff was prioritised by senior leaders. They had recently reviewed the national staff survey results for maternity for the past 3 years. Staff response rates had increased. They had collated this information and shared it with staff during a series of six listening events, over the past year. The listening events were used to get feedback from staff in order to create an action plan and improve the service. Staff had also been given the opportunity to provide anonymous feedback.

The SLT had held consultations with obstetric staff about the rotas and out of hours consultant cover. They listened to staff concerns and altered job plans to make it easier for staff who lived further away. They had also split some job plans to make it easier for them to cover weekends. They told us this improved safety because more than one consultant was required to cover the unit safely over weekends. Obstetric staff had been consulted with and listened to.

Staff groups could raise concerns at monthly staff safety meetings. These were captured on an action log and discussed at the safety champion meetings.

The service had a Coach, Leadership & Organisational Development Consultant working with them on a variety of projects. Projects were triggered either by staff or service-users. Maternity services had a dedicated human resources consultant to ensure there was advice and support available. They assisted with actions required because of the staff survey. The service had undertaken a board seminar in November 2020 to provide the board with an oversight of the challenges and achievements within the service.

A 'Whose shoes' approach to designing and engaging maternity services had been planned. This meant staff chose a theme they wanted to explore. For example, communication. Themes were then developed, and an infographic poster produced to share the information with teams. This helped staff to understand where improvement was needed.

The service had established a neonatal wellbeing group during the COVID-19 pandemic. The group had weekly meetings which were very well attended. They did not have an agenda but discussed issues broadly. For example, stress. They had also been given a 'rest pod' and received very positive feedback about the group.

The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP). The MVP was in weekly contact with the service. They also had open access to the Director of Midwifery and quarterly formal meetings with representatives from the Trust.

The local MVP were recruiting for people from black and ethnic minority backgrounds, to diversify and reflect the voice of all women and mothers. The local maternity system had ring fenced a funding to support their MVP.

The service was working collaboratively with service users, neighbouring trusts, and commissioners via the LMS, to ensure national recommendations for maternity care were implemented across the region.

The service shared a compliments booklet through their regular maternity bulletin to showcase specific staff or compliments. They also featured a staff award nomination scheme to celebrate staff achievements and hard work.

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Learning, continuous improvement and innovation

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

The trust developed maternity training pathways during the pandemic. These included a table- top exercise for emergency caesarean sections and testing their existing plan for treating women with covid19.

They had previously trained staff to use a CTG training package. However, they were currently re-developing their guidance in-line with physiological electronic fetal monitoring interpretation. Several staff had completed the Edwin Chandraharan course. This course aimed to provide evidence-based training on CTG interpretation based on fetal physiology and pathophysiology of intrapartum hypoxic injury. Following the course, the attendees were developing a CTG sticker (red, amber or green) to correspond with different physiological stages. The sticker was being sent to the relevant stakeholders for consultation. This was to improve outcomes for babies, whilst reducing unnecessary operative interventions.

They had developed a new baby clinic during the pandemic (OPAC clinic). This service supported babies to stay at home whilst being treated for sepsis. Babies came into the clinic for one hour to have an intravenous dose of antibiotics, after which they returned home. They audited this service. It was embedded into the organisation as their audit results had shown there had been no readmissions.

The trust shared a joint initiative with Dr Foster team. Dr Foster is the leading NHS provider of intelligent analytics. This initiative was known as 'Clinical Spotlight'. The purpose was to take key metrics relating to maternity care/safety and benchmark with similar units and other trusts. This report was circulated to midwifery and obstetric staff and discussed at obstetric consultant meetings. The service was continually monitoring their risk and performance.

Areas for improvement

MUSTS

Action the trust MUST take is necessary to comply with its legal obligations

- The service must ensure there is a process to ensure the prevention and detection of the spread of infection in all areas (Regulation 12 (1)(2)(h).
- The service must ensure women are allocated a lead professional at their first booking appointment (Regulation 12 (2) (a)).
- The service must ensure women are risk assessed at every appointment during their pregnancy and document that their risk has been reviewed (Regulation 12 (2) (a)).
- The service must ensure women are routinely asked about the risk of domestic abuse throughout their pregnancy (Regulation 12 (2) (a)).
- The service must ensure they always use systems and processes to record and store medicines safely and in line with the provider's medicine policy (Regulation 12 (2)(g))
- The service must ensure policies and guidance are reviewed in a timely manner. (Regulation 12 (2) (b)).

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- The service must ensure they have a process to ensure they have oversight of transfer times from all community settings (Regulation 17 (2)(a) (b)).
- The service must ensure they have a regular audit mechanism to demonstrate compliance with standards and procedures and to monitor improvement (Regulation 17 (2)(a) (b)).
- The service must improve the culture and ensure staff are actively encouraged to raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care. (Regulation 12 (1)(2i)).

SHOULDS

Action the trust SHOULD take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services;

- The service should ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).
- The service should consider the environment to ensure women and their families are always treated with respect and dignity.
- The service should ensure there is a dedicated room on labour ward for women and families who have experienced a bereavement. They should consider this environment to meet their needs.
- The service should ensure their training in emergency procedures is effective, and all staff understand how to support an emergency evacuation from a birthing pool, when there are less than five staff available.
- The service should consider including baby abduction as part of their regular skills and drills.
- The service should ensure all staff are aware when services and maintenance work has been undertaken or is due.
- The service should consider displaying safety information.
- The service should scrutinize information around ethnicity and use it to inform decision around service development and in monitoring performance.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and an inspection manager. The inspection team was overseen by Amanda Williams Head of Hospital Inspection.