Hull University Teaching Hospitals NHS Trust

Hull Royal Infirmary

Inspection report

Anlaby Road
Hull
HU3 2JZ
Tel: 01482675783
www.hey.nhs.uk

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Ratings

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

Our findings

Overall summary of services at Hull Royal Infirmary

Inadequate 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Hull Royal Infirmary.

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

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

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

We reviewed the rating of the location, our rating of this hospital went down

Maternity is rated inadequate.

How we carried out the inspection

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

Maternity

Inadequate ↓↓

Our rating of this service went down. We rated it as inadequate because:

Systems, processes, and risk in the antenatal day unit / triage department were not well managed which led to long delays in women and birthing people being seen and a chaotic environment which was not fit for purpose.

Staff did not complete training in areas where there was a known risk, and the service did not have a clear policy that set out training requirements.

Staff did not always work well together across the different units of the service for the benefit of women and birthing people and some staff spoke about unkindness between staff.

Staff understood who to share safeguarding concerns with and we saw safeguarding care plans in records. However, communication between staff when there was a safeguarding risk was not well embedded.

Staff did not always risk assess women and birthing people, act on presenting risk in line with national guidance or handover concerns effectively to ensure appropriate care was provided.

Serious incidents were not always reviewed in a timely manner and lessons were not always learned and embedded from serious incidents and external investigation when there were poor outcomes for women and birthing people, to reduce reoccurrence.

There was a lack of operational oversight and management of risk. Governance systems and processes to assess, monitor and manage risks within maternity services were not robust. Actions the service told us had been taken to mitigate concerns raised by CQC following our inspection on the 15 March 2023 were not maintained when we returned to the service on 24 April 2023.

The service was reactive to concerns and there was a lack of clear strategy to improve the safety and quality of the service.

However:

Recruitment was on-going to improve the current staffing situation and increase the management support structure. International recruitment had been successful and the use of non-midwifery staff to support in non-clinical areas alleviated some pressures.

The service had started to identify some concerns and take action to set up maternity specific meetings where risk and learning from serious incidents would take place.

The service was clean and infection risk was well controlled. The environment, except for antenatal day unit / triage, was fit for purpose, clean and well-maintained.

Staff managed medicines administration well, but storage was not always secure in some areas. Care records outside of the antenatal day unit / triage department were comprehensive. The service was working across both paper and electronic systems, but plans were in place to move to digital ways of working.

Maternity

Following our first inspection we raised our concerns with the trust and received assurances the trust had taken action on our concerns. However, following our second inspection on 24 and 25 of April we imposed urgent conditions under section 31 of the Health and Social Care Act 2008 on the registration of maternity services at Hull Royal Infirmary.

Is the service safe?

Inadequate 

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

Mandatory training

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

There was no policy in place to outline what training was mandatory and how often training topics should be completed in line with staff roles. An exercise had been completed to ask staff what areas of training they felt they needed further development in, which was concluded in January 2023. At the time of our inspection no action had been taken to progress the findings and address identified shortfalls.

We were unable to review mandatory training compliance we were told this was due to the lack of trust policy, however, training records we did view showed that 39% of staff had completed the perinatal institute growth assessment protocol training and 51% of all staff groups had completed the fundal height measurement training against the trust target of 90%.This training supports staff in correctly identifying if babies are the expected size against gestational age. We saw a number of incidents which demonstrated several missed opportunities by professionals to identify babies who were small for gestational age.

There was no data recorded for the number of staff who had completed pool evacuation training, and this was not part of a regular training schedule. Perinatal mental health training, which the service told us was mandatory, had been paused during the COVID-19 pandemic and restarted in 2023; no figures on the number of staff who had completed this training to date were shared.

Training for Practical Obstetric Multi-Professional Training (PROMPT) was above the trust target of 90% at 96%. 93% of staff had completed neonatal resuscitation training and 95% of staff had completed fetal monitoring cardiotocography (CTG) training against the trust target of 90%.

Staff had not received training in how to evacuate a birthing pool in the event of an emergency.

We requested but did not receive the training compliance figures for support staff/unregistered nursing staff.

Some staff told us that managers allowed protected time to attend face to face training, but protected time was not provided for online training, other staff told us they were expected to complete training in their own time. They also told us that managers monitored training and alerted staff when they needed to update their training. Systems to ensure oversight of the training completed were dis-jointed and made it difficult for the service to demonstrate compliance. We sought further information from the service about their training records and compliance and the service provided additional information and clarification on some areas.

Maternity

The service had a specialist midwife known as a practice learning facilitator who was passionate about the role and addressing the known shortfalls. However, due to staffing issues, high workload, and limited capacity they told us they were unable to progress known issues further.

Safeguarding

Staff had not always complete training on how to recognise and report abuse and did not always know how to apply it.

Staff had not always received training specific for their role on how to recognise and report abuse. Training records showed that not all staff had completed safeguarding adults' level 3 and safeguarding children level 3 training. The trust's policy did not outline the expectations for staff in line with the intercollegiate guidelines (2019). Information provided by the service did not provide evidence that medical staff completed level 3 adult safeguarding training. This was not in line with intercollegiate guidelines (2018). However, 76% of medical staff had completed the safeguarding children level 3 training although this was below the 90% trust target. Safeguarding adults' level 3 training was completed by 60% of midwives and 72% had completed the Safeguarding children level 3 training, both fell short of the 90% trust target.

Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Safeguarding concerns were identified, and women and birthing people had birth plans with input from the safeguarding team. However, staff were not familiar with the coding system used on patient notes to communicate safeguarding concerns discreetly. One staff member was carrying an aide memoir with the definitions of the codes, but other staff did not have access to this and could not explain the coding system when asked.

Staff did not always identify adults and children at risk of, or suffering, significant harm. During our second inspection we observed a patient presenting where there were significant safeguarding concerns, we observed staff did not recognise this and reviewed the electronic record only when prompted by the CQC team. This put women and birthing people at risk of harm.

There was a lack of staffing in the safeguarding team which meant that it was not always possible for staff to attend safeguarding meetings where information was shared. This was a recognised risk on the risk register and some mitigating measures had been taken.

Staff could explain how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding team who staff could seek support from when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 6 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning guidance was in place for domestic staff to follow but no records were kept to evidence when cleaning was done.

Leaders completed infection prevention and control and hand hygiene audits.

Data provided showed hand hygiene audits were completed every month for the last 3 months in 3 of the 5 maternity areas, we did not receive evidence of hand hygiene audits carried out in the antenatal day unit and only 1 month's audit was provided for 1 of the units. In the last 3 months compliance was consistently 100%.

Audits were completed to check the cleanliness of the service. There were 3 different types of cleaning audits in use which varied in terms of detail. Where shortfalls were identified we saw no evidence of action plans to address the issues.

The service generally performed well for cleanliness, but one audit scored 65% due to poor documentation.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Environment and equipment

The design, use of facilities, premises and equipment did not always ensure women and birthing people were safe. Staff were trained to use equipment and clinical waste was well managed.

Some areas of the service did not have suitable facilities to meet the needs of women, birthing people, and their families.

We raised concerns about how one of the waiting areas was managed because it did not facilitate the effective monitoring and oversight of women and birthing people or allow staff to easily identify if there was a deterioration in their condition. This waiting area was shared by the antenatal day unit (ADU), the antenatal clinic and the early pregnancy assessment unit; women and birthing people who were amber (medium) risk had been asked to wait in a café area and were alerted with a handheld buzzer when staff were ready to see them; whilst those rated green (low) risk were in the waiting area. We raised this as a concern and steps were taken to ensure women and birthing people at higher risk remained in clinical areas. Leaders told us there were longer term plans to move the antenatal assessment unit to different part of the women's and children's hospital. However, the on-going risk of the current layout had not been managed or mitigated and was not recognised on the trust's risk register.

Following our first inspection, leaders shared with us improvements they had made to the waiting area to allow better oversight of those women and birthing people most at risk. When we returned on the 24 and 25 April 2023, we found there was closer oversight of women RAG (Red, Amber, Green) rated amber remained in the waiting area and those rate green were given the handheld buzzer.

The service did not always have enough suitable equipment to help them to safely care for women and birthing people and babies. For example, on the antenatal day unit there was no neonatal resuscitaire and there was no plan in place for how staff would access one in an emergency. We raised this with leaders who put a plan in place to ensure staff understood where the nearest emergency equipment was and how to respond in such an emergency.

There was a bereavement suite located on the labour ward. As a result of its location and access to the suite it did not meet the standards set out by the Department of Health's Health Building Note 09-02 maternity care facilities.

Maternity

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

Staff carried out daily safety checks of specialist equipment.

Staff regularly checked the cleanliness of the birthing pool and guidance for the cleaning of the birthing pools was developed in consultation with the infection prevention control team. Staff were unable to describe the legionella testing of the water supplies.

The service did not always have suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support, however there were limited facilities for women and birthing people's families to make food and drinks for themselves and food provided was limited. There were also no areas to allow people to spend time away from their beds, as quiet lounges were being used by staff.

Call bells were accessible to women and birthing people if they needed support and staff responded when called.

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

Assessing and responding to risk

Staff did not complete risk assessments or take action to remove or minimise risks. Staff did not always identify and act quickly to prevent deterioration of women and birthing people at risk.

We are not assured there were effective systems and processes in place for managing and responding to patient risk. Staff did not always complete risk assessments using a recognised tool for women and birthing people either on, or prior to arrival to antenatal day unit (ADU) / triage or when transferring to antenatal ward when ADU / triage closed. Furthermore, risks were not always regularly reviewed. Staff did not use an evidence-based, standardised risk assessment tool for maternity triage. There was a lack of standardised systems, processes, and guidance for staff to use. There were multiple versions of risk assessments in circulation which meant that a consistent approach was not possible.

There was no senior oversight of the ADU / triage area and staff told us there was a lack of leadership and support for the staff working in this area. The service had not completed any audits to monitor waiting times and the midwifery reviews for the women and birthing people attending. There was a lack of appropriate escalation processes at times of high acuity and a lack of medical support to assess and manage risk. We raised this as a concern after our first visit to the service and were provided with assurances, however on return to the service we found these had not been sustained and maintained. We took enforcement action to ensure the safety of women and birthing people.

The service operated a telephone triage system in which women were advised to call a central number if they had concerns during their pregnancy. They would then be given advice over the phone or asked to attend the antenatal assessment unit. The lack of structure, guidance for staff, record management and oversight of this presented a real risk to women and birthing people.

Maternity

Leaders did not monitor waiting times and make sure women and birthing people could access ADU / triage services in an emergency when needed. Women and birthing people did not receive treatment within agreed timeframes and national targets despite issues being identified from serious incidents and HSIB (Health Safety Investigation Branch) investigations.

Staff did not always share key information to keep women and birthing people safe when handing over their care to others. There were paper care records which meant key information was not always documented. The ADU / triage was not a 24-hour service and the process for transferring women to the antenatal ward when the ADU / triage unit closed at 20:00 was poorly managed. There was a lack of communication and handover between the two transferring teams this meant it was not always clear what action had been taken and what was still required to ensure the best outcomes from women and birthing people. Staffing pressures and lack of appropriate facilities on the antenatal unit placed women and birthing people at significant risk. There was not always enough appropriate waiting areas and beds for women moved from ADU / triage to the antenatal ward and insufficient staffing led to further delays. We saw evidence of how these issues had negatively impacted the care provided and led to poor outcomes for women and babies.

Risks associated with the inadequate triage systems had been highlighted both internally following serious incident reviews and by external bodies as part of an investigation by healthcare safety investigation branch (HSIB) cases. We saw no evidence of action taken to prevent reoccurrence or mitigate risk.

Shift changes and handovers did not always take place to ensure all necessary key information to keep women and birthing people and babies safe. Staff contacted us to inform us of poor outcomes because of a lack of handover following our initial site visit. We returned to the service to follow up on these concerns and risk. During the inspection we attended staff handovers and found key information needed to keep women and birthing people and babies safe was not always identified and shared. Safety huddles were not attended by all departments which meant leaders were not up to date with key information or acuity across the service. Handover sheets did not always use a structured format. We requested and did not receive handover audits. This issue had been raised by staff previously and actions listed included the use of SBAR (Situation, Background, Assessment, Recommendation) handovers, which describe the situation, background, assessment and recommendation for each person. However, we found this had not been embedded and staff confirmed that this was not standard practice.

From records reviewed staff used the fresh eyes approach to safely and effectively carry out fetal well-being checks. We requested audits from the last 6 months to ensure leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The service provided an audit summary of 15 sets of records from January 2023 to March 2023. They also provided a data capture for a 2-week period in May 2022; it was unclear how many records were reviewed from the data provided. We saw no evidence of an action plan from the findings presented for May 2022 which included findings that only 35% of commencement stickers were fully completed and 3 cases had no CTG records completed. The data presented in these two documents was variable and records were inconsistent. We were not assured regular audits of CTGs were completed, and we were not assured that, where needed, action was taken to identify and implement improvements.

We reviewed 1 serious incident where the lack of CTG had led to poor outcomes for those involved. This had not been appropriately graded as part of the perinatal mortality review of the baby's death. This meant that the failures in care provided had not been fully recognised and shared with the family involved. We also found that not enough action had been taken to learn from this and reduce the chance of re-occurrence.

Nationally recognised tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people were in place, however, staff did not always use them to identify women and birthing people at risk of deterioration

correctly or escalate concerns appropriately. The service shared a summary of results from their monthly MEOWS audits which analysed if records were fully completed, and score escalated appropriately. The audits included 5 records per month which equated to 1 record per unit. A summary of the findings for January 2023 to March 2023 for 15 set of records scored 100%. However, in 1 person's records we reviewed the total scored had not been calculated on 9 out of 21 separate occasions.

Staff completed new-born risk assessments when babies were born using recognised tools and reviewed this regularly. The service had set up a newborn and infancy physical examination (NIPE) clinic to manage this.

The service provided transitional care for babies who required additional care, this was overseen by the paediatric team.

Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns by contacting the vulnerabilities specialist midwife. There were no ligature risk assessments in place across any of the units, however 1 midwife told us that rooms had been identified as rooms ligature light (a low-level risk for ligatures).

The service used a translation telephone service for non-English speaking women and birthing people; however, this was not well advertised to those using the service. We saw no written information available in different languages around areas of high risk such as reduced fetal movement.

The service provided the maternity dashboard from April 2022 to January 2023. We saw there was limited information regarding thresholds, however, we saw the threshold for 3rd or 4th degree perineal tear was less than 20 but the red flag was where there was more than 20. It was not clear if this was during the year or per month. Data provided showed:

Between April 2022 and January 2023, 39 women and birthing people had a 3rd or 4th degree perineal tear, with 8 3rd/4th degree tears occurring in December 2022.

Between April 2022 and January 2023, 1031, women and birthing people had a postpartum haemorrhage less than 1500mls, with 121 occurring in September 2022. Seventy-nine women and birthing people had a postpartum haemorrhage which measured between 1500mls and 2000mls with 14 occurring in June 2022. Forty-four women and birthing people had a postpartum haemorrhage which measured greater than 2000mls with 13 occurring in April 2022.

Records

Staff did not always keep detailed records of women and birthing people's care and treatment. Records were not always clear or up to date. Records were stored securely.

Women and birthing people's notes were not always comprehensive in the ADU / triage area of the service. The service used a combination of paper and electronic records. There was no centralised way of recording calls made to the maternity service by women and birthing people. Calls were taken and managed across several different units and so information was not always shared or followed up on where required.

We also had concerns around the documentation used to support handovers of cases when women and birthing people would move from one area of the service to another: for example, from antenatal assessment unit to antenatal ward. As outlined above this impacted the care people received.

Maternity

We reviewed 13 paper records and found records across other areas of the service were generally clear and complete in terms of standardised questions staff would ask women and birthing people.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

On the day of inspection midwifery staffing levels were below the expected levels across each department of the service. Women and birthing people told us low numbers of staff made them feel unsafe.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A red flag event is a warning sign that something may be wrong with midwifery staffing. There had been 31 red flag events reported in the last 6 months, all of which occurred on the labour ward. From observations during inspection and feedback from staff members not all red flag incidents had been reported across the maternity service.

Staff told us that there was a lack of action taken by leaders when staffing levels put women and birthing people at risk. The board maternity staffing report highlighted that "a recent 2022 royal college of midwives (RCM) survey highlighted that "Only 5.9% of midwives said that there are enough staff at their organisation for them to do their job properly." The service invested in the Retention, Recruitment, and Pastoral Midwife (RRPM) to support ongoing work with existing staff and new starters.

Managers calculated and reviewed the number of midwives needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in November 2021. This review recommended 187.89 whole-time equivalent (WTE) midwives compared to the funded staffing of 179 WTE, a shortfall of 8.89 WTE staff. The report also identified the need to uplift the midwifery establishment by a further 9.29WTE for additional specialist and management roles to support the delivery of key national drivers rather than deliver direct clinical care. There were plans in place to address the shortfall however the escalation plans were not followed and demonstrated throughout our inspections.

A review of staffing vacancies presented to the trust board in January 2023 identified that the number of registered midwives in post was 176.63 WTE against the budgeted 187.89 WTE, however this is coupled with 10.36 WTE midwives either leaving or reducing their hours and 15.96 WTE on maternity leave; leaving a current total vacancy of 30.30 WTE midwifery posts.

Community midwives from May 2022 to January 2023 had 7341 planned hours verses 5218 actual hours, a shortfall of 2123 hours over 9 months.

There was no supernumerary flow co-ordinator on duty at all times who had oversight of the staffing, acuity, and capacity. The director of midwifery acknowledged that the current structure within the management team to support the service was not right, and several job advertisements were out for recruitment to try and address the issues.

The ward managers did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but

staff told us this was at short notice and expected to work in areas unfamiliar to them. Staff also told us that there was not always a sense of teamwork between the units and staff could be unkind to each other when trying to address staffing shortfalls in different areas of the service. Acuity and staffing levels on the antenatal assessment unit was not reviewed in the same way other areas of the service were and so there was a lack of oversight of the challenges faced from a leadership perspective.

The service did not always make sure staff were competent for their roles. Managers had not regularly appraised staff's work performance and held supervision meetings with them to provide support and development.

Seventy three percent of midwifery and ancillary staff in the women's and children's hospital had an up-to-date appraisal, however, the target rate for appraisals was not shared.

The service had specialist midwives to support midwives including a practice learning facilitator and a pastoral midwife. Specialist midwives told us that they were limited in what they could achieve due to staffing issues. The pastoral midwife told us that staff wellbeing was the focus of their role.

Midwife feedback about whether they felt supported varied across the service, some felt very supported, listened to and able to raise concerns and others did not.

Medical staffing

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

The service did not have enough medical staff to keep women and birthing people and babies safe. The medical staffing did not match the planned number. There were 14 substantive consultants when there should have been 20.

The service used locum consultants to manage the deficit. There was no finalised induction policy or process at the inspection to support locum doctors, a draft version of a standard operating procedure was shared when requested however this was awaiting final sign off and so was not in use at the time of inspection.

The service did not always have a good skill mix and availability of medical staff on each shift, and this impacted on waiting times, in the ADU / triage in particular. We raised this as a concern after our first site visit and leaders told us there would be a dedicated medical member of staff allocated to the assessment unit. However, staff told us this was not sustained and maintained when we returned to the service and there continued to be a lack of medical presence in this area which impacted on the review of women and birthing people.

The service always had a consultant on call during evenings and weekends shared across gynaecology and obstetrics.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Medicines

Maternity

The service used systems and processes to safely prescribe, administer and record medicines however they were not always stored securely.

Staff did not always store and manage medicines safely. Across the delivery suite and midwifery led unit we observed several occasions where medicines were stored between 2 birthing rooms. These could be accessed on each side by either birthing room where drugs were stored in an unsecure fridge. This was raised with the director of midwifery, and they took action to address this by the end of the site visit.

Medicines were stored securely but there were no on-going monitoring checks in place around the storage of these. Clinical rooms across other areas of the service where the medicines were stored were locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 9 prescription charts and found staff had correctly completed them.

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

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

Incidents

The service did not manage safety incidents well. Staff recognised and reported incidents and near misses. However, the service did not investigate incidents in a timely or effective manner or shared lessons learned with the whole team and the wider service.

Staff explained that they knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed several incidents reported in the 12 months before inspection and found them to be reported appropriately.

Managers did not review incidents on a regular basis so that potential themes and trends could be identified and actions to identify and mitigate risk. A review of the national learning and reporting systems showed between 01 April 2022 and 31 March 2023 there were 56 occasions where babies were born small for gestational age or growth restricted. Therefore, there was a potential 56 occasions where there was an increased risk to women and birthing people, a concern that had been identified in previous serious incidents within the service. Further action was needed to mitigate known risk.

Managers did not carry out investigations in a timely or thorough manner. We reviewed 4 serious incident reviews and found that staff had involved women and birthing people and their families in the investigations. However, although they were involved, it was not always in a timely or respectful. For example, there were long delays in some circumstances between the date of the incident and the serious incident investigation starting. One serious incident was not reviewed for 12 months, and another waited 4 months.

Maternity

All incidents of babies who die should be reviewed using the perinatal mortality review tools (PMRT). This process was intended to allow a systematic, multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death. We were not assured the systems and processes surrounding the PMRT reviews were robust or effective. We found incidents were graded incorrectly regarding the appropriate level of care received. The perinatal mortality review tool graded the care of the mother and baby as C; which meant identified care issues may have made a difference to the outcome for the baby. However, following a review of the information provided it was established that this incident should have been graded as D which meant the identified care issues were likely to have made a difference to the outcome.

We also found 1 incident had been open since 2021 and there were 4 other cases awaiting review. A lack of oversight and monitoring of actions had resulted in lessons not being learned. For example, a safety recommendation from an external HSIB case made recommendations in November 2022 which stated, “The Trust to review local guidance to ensure it provides a robust process for the triage of mothers.” At the time of inspection, we identified concerns around the triage process and lack of local guidance. We share our concerns with leaders immediately and the service provided us with assurances the concerns had been addressed. However, on a return visit to the service we found that these changes had not been maintained and so regulatory enforcement action was taken.

We were given conflicting information around who managed duty of candour for the service and there was a lack of clear systems and processes in place around this. However, there was evidence in reports that this had been considered and actioned.

We found draft reports shared with families for comment were at times insensitive and not quality checked prior to being sent out leading to further potential distress for women and birthing people. There was no evidence of managers reviewing incidents potentially related to health inequalities.

Actions identified in both internal and external reviews of incidents had not been effectively shared and learned from. We saw evidence of a lack of learning and repeated failures in the delivery of safe care and treatment as a direct result of lessons not being learned. Specialist midwives who had responsibility for sharing lessons learned from incidents told us they had tried to engage with staff but felt there was a lack of oversight and management from senior managers.

There was little evidence that frontline staff received feedback from investigation of incidents, both internal and external to the service. Newsletters shared did not always include learning from serious incidents or HSIB reports.

Staff meetings were minimal and did not cover all areas of the service. Staff provided feedback around concerns we found on inspection to improve the care of women and birthing people.

There was no evidence that changes had been implemented and effectively embedded following feedback from staff. For example, staff had raised in a safety walk around that there were issues with handovers due to timings, poor staff attendance and lack of documentation to support an SBAR model. This was still an issue when we inspected, and we saw how this had led to poor outcomes for people using the service. Action trackers shared were not effective in monitoring progress or driving change within the service.

Managers failed to debrief and supported staff after a serious incident. Staff told us they felt unsupported at this time and were expected to continue with caring responsibilities with no acknowledgement of the impact to their wellbeing.

The service had no ‘never’ events.

Maternity

Is the service well-led?

Inadequate 

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

Leadership

Leaders demonstrated that they understood some of the issues the service faced, however, they were not always managed and prioritised effectively. Feedback from staff around visibility and approachability of the service leaders was variable.

Maternity services at Hull University Teaching Hospitals NHS Trust were part of the family and women's health division. The maternity department was managed by the Director of Midwifery, a Director of Obstetrics, Medical Director, Nurse Director, and Clinical lead for neonates. They were supported by obstetric doctors, specialist midwives and midwifery matrons. The Director of Midwifery acknowledged that there was a lack of managerial support sitting below the senior leadership team as there was no deputy director of midwifery or head of midwifery; recruitment was ongoing for more operational matron posts to strengthen the team. These vacancies impacted on the capacity of the senior leadership team to implement and embed changes that were needed.

The leadership team were receptive to areas identified for improvement however there was limited assurance on how this would be achieved.

Whilst leaders had an awareness of some of the issues the maternity service faced, there was a lack of clarity and direction on how this would be addressed to improve the quality and sustainability of the service.

Recruitment plans were in place but there was a lack of clear escalation processes when the service was experiencing high levels of acuity and staff shortages. Staff told us they did not feel listened to or supported at these times despite sharing their concerns with leaders in the service.

The ADU / triage environment was chaotic without clear operational oversight or leadership to carry out work in a calm and systematic way. Service-level staff said service leaders were not visible in this area or responsive to concerns which was indicative of poor communication throughout staff groups. Staff told us this impacted on the civility of the team members across the different areas of the service.

Recent changes within the leadership team were spoken of positively and some staff members told us leaders were approachable and supportive. However, other staff members in some areas of the service did not feel they were given the same level of support as their colleagues. Midwifery staff told us they were well supported by their direct line managers, ward managers and matrons, however they acknowledged there were capacity issues and staff shortages which presented them with challenges in providing the required support.

Maternity

The service had maternity safety champions which included a non-executive director. Action plans shared evidence a lack of action taken to address concerns shared by staff. The safety champions job plans shared were incomplete and lacked direction and goals for the upcoming year. An extraordinary meeting was held in November 2022 to look at plans to make the meeting a platform for change. This was poorly attended, and changes identified had not been implemented.

The executive team rarely visited wards. We reviewed meeting minutes in which a non-executive director voiced that they did not feel this was a priority. This was not challenged by others attending the meeting but raised at a later date. A new non-executive director was due to start in post at the time of our inspection. When we spoke to them, they acknowledged that ward and department visits were a key part of their role as a safety champion.

Staff had been supported to develop their skills and take on more senior roles, however, some midwives had self-funded courses to enhance their own skills. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress and upskill in partnership with local universities.

Vision and Strategy

The service did not have a vision and strategy in place for the service. However, an individual strategy was in place for specific improvements within the service.

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action. Goals and guiding values were documented in some policies, but there was no clear vision for the service and strategy to achieve it.

The service had developed a digital strategy in collaboration with another trust and partner agencies and this did outline the vision and strategy to achieve the goal of a digital service by 2025. This had also considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services.

Culture

Some staff did not always feel respected, supported, and valued. Pressures on staffing and meant that care was at times task focused rather than patient focused. There was a lack of consideration given around inequalities and the impact on outcomes.

The feedback from staff about whether they felt supported and valued was variable. Staff told us there was at times unkindness between staff and some teams worked in silos. Staff told us that when concerns were raised, they were not always listened to and following incidents they were not provided with compassion and support from leaders, which can be indicative of a closed culture.

We were not provided with action plans to evidence what action was being taken in relation to a recent staff survey in which staff demonstrated high levels of dissatisfaction in their roles.

Other staff members told us they were supported by their managers, and they were comfortable raising concerns with leaders who were visible.

Leaders were aware of the cultural issues within the service and training around civility was taking place, this included leadership specific training for staff members with people management responsibilities.

Maternity

There were insufficient doctors to cover the on-call rota for gynaecology and obstetrics, this put additional pressure on the medical staff and increased the risk of burnout. This also impacted on the clinical support provided in clinical areas. The board were aware of this, and the staffing levels had been reviewed and recruitment of doctors was on-going. Concerns were shared in meetings by consultants around the risk of burn out to doctors and risk this presented to the service. This included a request for the lack of anaesthetists to be included on the risk register, but this did not happen. Efforts were on-going however to recruit more doctors.

Staff were not always focused on the needs of women and birthing people receiving care. For example, staff told us that some consultants were reluctant to see women and birthing people who were not under their care; this was an issue raised with leaders previously but had not been addressed. Staff worked within an environment that was at times chaotic and task focused which did not allow for a culture that placed peoples' care at the heart of the service or recognise the power of caring relationships between people. Staff wanted the service to improve but did not always have the capacity to bring about those changes. The retention and pastoral specialist midwife was working to support staff's well-being but this mainly focused on the labour ward due to time constraints.

Leaders had not done enough to understand how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. Outcomes and investigation data had not been reviewed to identify when ethnicity or disadvantage affected treatment and outcomes with the aim of improving care. Staff could identify the demographics of the population they served but were unable to articulate the issues faced and how they would provide better care.

During our inspections we observed women and birthing people who faced barriers to care but little was done to reduce the impact. For example, the antenatal day clinic did not operate appointment times and so women and birthing people were waiting long periods of time to be seen; there was no consideration given to access to food and hot drinks during these times. We also observed how reliance on public transport impacted women and birthing people's ability to wait long periods of time to been seen and attend additional appointments.

We requested but did not receive sufficient information around how complaints were managed, however, the service provided evidence which showed between April 2022 and January 2023 there was 40 complaints. Therefore, we could not assured that complaints were handled in a fair and timely manner. Complaints were not regularly discussed as part of the obstetric governance meeting despite this being a fixed agenda item and were not a regular discussion topic in staff meetings and engagement information we reviewed.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels did not always demonstrate a clear accountability for their roles. Opportunities to meet, discuss and learn from the performance of the service were not frequent or specific enough to drive improvement.

We found there was a lack of robust governance systems and processes to assess, monitor and manage risks within maternity services. Staff, including senior leaders, could not clearly articulate how risks were managed or actions put in place to mitigate risks and reduce the reoccurrence of incidents. We found a lack of operational management and oversight to mitigate risks which we identified in a letter of intent issued by CQC dated 17 March 2023 setting out the concerns we found at our inspection on 15 March 2023. We found a failure of the operational management team to

continue and sustain the actions set out in the service responses dated 17 March 2023 and 21 March 2023. CQC had to escalate further concerns with the trust's executive team about patient safety and we asked the service to make further urgent improvements and issued enforcement action. CQC continues to monitor the progress the service has made with these actions through engagement with the trust.

There was no evidence to support that senior leaders had sufficient oversight and understanding of where the department was failing to meet standards in care. We saw staff failing to provide the required standard of care and a failure to follow and implement best practice. This was not through lack of care or compassion but due to a lack of effective systems, processes, and staffing to do so. There was a lack of oversight to ensure issues were identified and addressed in a timely manner.

The same failings we identified on inspection had been previously identified in both internal investigations following incidents and external investigations. We saw limited or no evidence that action had been taken to address the repeated issues.

Leaders were not always sighted on the relevant risk as required for them to mitigate risk and bring about change in the safety and quality of the service. This included the safety champions not discussing maternity serious incidents, this had been highlighted in their August 2022 meeting but was still not happening at the meeting in January 2023.

Staff understood their role within the wider maternity team however voiced that they were unable, due to capacity issues and lack of support from senior leaders, to implement and address issues. Staff could not articulate that they knew how to escalate issues to the clinical governance meetings and divisional management team. Information was not effectively shared back to sub-committees and to all front-line staff.

The Family & Women's Health Group Board Meeting met monthly, we reviewed the last 3 months meeting minutes and found maternity services only was included in the most recent meeting minutes shared. We reviewed governance meeting minutes and found that complaints were not regularly discussed to ensure learning and quality improvement. Patient voice through engagement with the Maternity Voices Partnership was also not evidenced in the obstetric governance meetings, despite this being a standing agenda item and expectation as outlined in the trust's policy.

Reports were shared with the board, however at times there was a lack of meaningful information of the shortfalls of the maternity service, in particular the risks around pre-term births, small for gestational age (SGA) births and compliance with growth assessment protocol (GAP) training.

We found that policies were not always in place to deliver high quality care according to evidence-based practice and national guidance. We found that policies were not implemented and associated guidance was not consistently followed in relation to risk management. For example, there were numerous versions of risk ratings for triage in use which differed from guidance in the policy. Lack of consistency in this area had led to poor outcomes previously for women and birthing people and continued to be a risk at the time of our inspection. We took enforcement action as a result of our findings.

Management of risk, issues and performance

Leaders and teams did not have systems in place to manage performance effectively. They had identified risks but plans to escalate relevant risks and issues or action taken to reduce their impact had not always been effective or timely.

Managers and staff did not always carry out a comprehensive programme of repeated audits to check improvement over time. They did not always audit performance and identified where improvements were needed. There was no evidence that managers shared and made sure staff understood information and findings from the audits. The audit program shared with us listed 32 audits. Out of the 32 listed audits only 7 were completed. 7 were classified as overdue/ neglected. 13 were unassigned and there were no progress updates documented. We saw from papers submitted to the board and in compliance papers reference to audits completed however these were not shared as part of the data request to CQC. We received summaries of audits completed in maternity in some areas. For example, CTG standards and use of reduced fetal movement stickers, however these were from a sample of 15 sets of notes in January, February and March 2023. As a percentage of the births the service has this was not sufficient to provide an accurate picture of the service. We were not assured that these audits were embedded as a way of reviewing and improving the service.

Minutes shared of the safety champions meeting also highlighted that audits were not considered a priority or seen as an opportunity to address potential risk and improve safety. There was no dedicated audit midwife within the service and so this was a time-consuming task that often sat as an extra responsibility in an already stretched workforce.

The service participated and reported it was compliant in all relevant national clinical audits prior to the deadline for submission. However, evidence provided in the months prior to the deadline they were not always meeting those standards. For example, in relation to saving babies lives element 5.1; which looks at the percentage of babies born under 34 weeks receiving a full course of steroids, within seven days of birth. The submission for October 2022 was 33%, November was 31%, December 2022 was 80% and January 2023 was 0%. A retrospective audit completed in December 2022 for the previous 6 months showed the service was compliant in 52% of cases against the standard of 80%. This meant the service did not consistently or routinely meet the required compliance and compliance was not embedded.

The service also did not have sufficient capacity in the pre-term specialist clinic and were not able to meet demand based on the current availability of doctors. Pre-term clinics would work towards early identification of pre-term babies and offer consistency in the management of these cases to improve the outcome of those affected. The service also had no provision for uterine artery Doppler scanning which is a way of checking the flow of blood in the vessels which can inform whether the baby will grow to its full potential. This was discussed at obstetric governance meetings and was included on the obstetric risk register. The risk assessment shared referred to the use of a uterine artery doppler scanning despite this not being available. A business case was put to the board to introduce pre-term clinics and doppler scanning however we could not see from information provided if this had been approved.

The demographics of the area and high levels of deprivation against the national average meant that women and birthing people were at greater risk of pre-term babies and small for gestational age babies.

Leaders did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. Some risks were identified through the incident management system and governance meetings. However, where risks around medical staffing were highlighted by clinicians for escalation to the risk register in February 2023, were not included on the risk register at the time of the inspection. The leadership team had identified some risks on the risk register and took action to mitigate these risks, however, there was no clear time frames for monitoring and completion or named person to own the risk. Therefore, the risk register was not fit for purpose.

There were plans to cope with unexpected events in the service by the way of an escalation policy for staffing shortages and/or high levels of demand or acuity on the ward. However, we found this policy did not reflect the management of the service when the ADU / triage unit closed at 8pm during the week, and 5pm on weekends. Staff told us the movement of women and birthing people to the antenatal inpatient ward when the unit closed impacted the safety of the service. We also found that that this had impacted the care provided to women and birthing people as risk was not

well managed or communicated. Staff told us the escalation procedure for medical review of women and birthing people attending the antenatal day unit was also not working effectively and this resulted in delays to women being medically reviewed as needed in line with their presenting risk. We raised this as a concern and changes were made after our first site visit. However, when we returned for the second time staff told us this had not been sustained for longer than 4 days. We took enforcement action as a result of this.

Information Management

The service did not collate reliable data and analyse and share this information to improve quality and performance of the service. The information systems were not integrated and there was a heavy reliance on paper records.

The service did not provide reliable data as part of the inspection; when we analysed the information they provided, we found it was inconsistent, incomplete, poorly analysed, and at times out of date. The service could not assure themselves that systems and processes were in place and effective. We were not assured the systems in place to collect and analyse data to understand performance and make decisions and improvements were robust or met the needs of the service. that These concerns were shared as part of the inspection and the service provided some clarification on the data provided and the systems used.

Staff were using both electronic and paper records but had a good working knowledge of how to navigate the systems. The service was working on the digital strategy to move towards digital ways of working and improve overall information management and this formed part of their action plan around MBRRACE.

Engagement

Leaders and staff engaged with women and birthing people, staff, equality groups, the public and local organisations to seek feedback on services, however this was minimal.

Leaders engaged with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP told us about work they were doing with women and birthing people from disadvantaged backgrounds and non-English speaking communities that may face barriers in accessing maternity services. A midwife was also engaging with local communities to try and educate women and birthing people on how to access services in a timely way.

The MVP worked alongside the Local Maternity System (LMS) and other MVPs to share experiences and good practice. The MVP told us that one of the main barriers to their effective engagement with women and birthing people was lack of hours and the geographical area that the trust covered. This was being raised with the board to improve the engagement and feedback achieved from women and birthing people by the MVP.

The service was also looking to recruit a patient safety partner to engage in service meetings and provide challenge from a patient perspective.

The service had a presence on social media and ran an “ask the midwife” service which offered non-urgent advice to women and birthing people on Facebook and had received positive praise from those using the service.

Maternity

The service made available telephone interpreting services for women and birthing people and pregnant people. This was not well advertised on the unit and so staff would be required to initiate use of this resource. This had been raised by the MVP on a recent walk around of the service and so action was planned to improve general communication and representation of diverse groups in the information displayed within the maternity service.

Information was not always collected at booking around ethnicity, and we saw no evidence of how this fed into quality improvement.

Leaders understood the needs of the local population but there was little evidence of work done to reduce the barriers to care and some of the ways of working in the service did not consider the demographics of the local population. For example, women attending an outpatient induction of labour were required to attend the hospital daily for check-ups and observations, the cost implications of this had not been considered.

Learning, continuous improvement and innovation

There was not always a clear pathway for staff to engage in continuous learning and improvement of services. Staff had a passion to improve the service, but quality improvement methods were not embedded, and more time and support was needed to implement them.

Leaders in the service told us they were committed to improving the service and were keen to learn and receive feedback on how they could improve. There were limited assurances provided around the quality improvement initiatives within the service outside of the work done to implement the Ockenden recommendations. There was a reliance on external parties to identify area of improvement. Where changes were made the impact in terms of sustainability and on-going monitoring was not always managed.

New roles within the service were being recruited to, to provide the resources to make the needed improvements. The service had introduced the role of Maternity Patient Safety Specialist, this was a new role which was implemented following national maternity reviews of safety and recommendations made. The role was to oversee quality of various incidents, thematic reviews, triangulating feedback and national drivers within the service.

A perinatal Improvement programme event was scheduled to take place following our inspection to support and develop the improvement programme.

A new maternity serious incident review group had been set up to provide a more in-depth review and greater challenge to maternity serious incidents as these had previously been reviewed in a generic serious incident meeting. This meeting was still in its infancy, but plans were in place to embed this further to build on learning and improvements in care.

The service did not have a specific quality improvement champion/specialist midwife and the training offers for staff around improvement of skills and their own development was not fully embedded. There were plans to improve this offer to staff as part of work done as part of the Ockenden review workforce recommendations.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Maternity

Action the service MUST take to improve:

Maternity

The service must ensure there is robust risk assessments in place for women and birthing people presenting to the service and all national guidance is followed to mitigate any identified risk. Regulation 12(2)(a)(b)

The service must ensure that there is a safe handover process when women and birthing people move between units of the service to ensure the health, welfare and safety of women and birthing people. Regulation 12(2)(i)

The service must ensure staff are up to date with maternity mandatory training modules. Regulation12(1)(2)(c)

The service must ensure that staff complete regular skills and drills training including pool evacuations. Regulation 12(1)(2)(c)

The service must ensure systems and processes are in place to assess, monitor and improve the quality and safety of the service. Regulation 17(2)(a)

The service must assess, monitor and mitigate the risk relating the health, safety and welfare of women and birthing people. Regulation 17(2)(b)

The service must ensure that records are accurate, complete and contemporaneous for each woman and birthing person. Regulation 17(c)

The service must ensure medical staffing for maternity ADU / triage is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18(1)

The service must ensure staff have access to appropriate safeguarding supervision and support to carry out their duties. Regulation 18(2)(a)

Action the service SHOULD take to improve:

The service should ensure that accidents and incidents are reviewed to identify potential health inequalities of those involved.

The service should consider the available facilities in inpatient areas to ensure women, birthing people and their families are able to independently access food and drinks.

The service should implement a training policy and procedure which reflects the needs of the staff group and how to address current shortfalls.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors and 3 specialist professional advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.