Care Quality Commission

Basildon University Hospital

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Ratings

Overall rating for this hospital

Are services safe?	
Are services effective?	
Are services well-led?	

Summary of findings

Overall summary of services at Basildon University Hospital

Basildon University Hospital is operated by Mid and South Essex NHS Foundation trust. The maternity unit at Basildon University Hospital provides a comprehensive range of services including; ambulatory care assessment, prenatal diagnostic screening, antenatal care services, perinatal mental health and counselling service, midwife led birthing unit, delivery suite and home birth service.

The maternity unit offers women the following birth options:

- Home birth: around 3% of all trust births are home births.
- Midwife-led birthing unit: Located on the Willow suite, consists of five delivery rooms (including two pool rooms) and four postnatal beds.
- Delivery suite: eight birthing beds and four enhanced care beds. There are two dedicated maternity theatres.

The maternity unit also includes Cedar Ward, a 33-bedded postnatal ward that also provides antenatal care and the Mulberry Suite, which is a seven-bedded ambulatory care assessment unit for all women from 14 weeks gestation.

From April 2019 to March 2020 there were 4,304 deliveries at Basildon University Hospital.

We last inspected the maternity service at Basildon Hospital in February 2019. The service was rated requires improvement overall; safe and well led were rated requires improvement, effective, caring and responsive were rated good.

During the 2019 inspection, we identified a number of concerns in the maternity service. As a result, requirement notices for breaches of regulation 12 and 17 of the health and social care act (2014), were issued against the trust. The requirement notices informed the action the trust must take to comply with its legal obligation, and we requested an action plan from the trust, outlining steps that had been taken to address the concerns we raised. The trust submitted an action plan following publication of the inspection report in July 2019. The trust submitted regular updates on the progress of the action plan and in February 2020, the actions relating to the maternity service were all signed off as completed by the trust.

In May 2020 we received information from an anonymous whistle-blower, raising safety concerns at Basildon Hospital maternity services. The information received and a review of the trust's incident reporting data highlighted a cluster of six serious incidents where babies were born in poor condition and subsequently transferred out for cooling therapy from March and April 2020. Cooling therapy is a procedure which can be offered as a treatment option for newborn babies with brain injury caused by oxygen shortage during birth. It involves bringing baby's temperature from the normal body temperature of 37°C to a temperature between 33°C and 35°C soon after birth and for a few days afterwards.

In response to the information we carried out a focused inspection on 12 June 2020 to follow up on the concerns raised.

During this inspection we:

- Spoke with 16 staff members; including service leads, matrons, midwives, doctors, midwifery care assistants and administrative staff.
- Checked 12 pieces of equipment.
- Reviewed 12 medical records.
- Reviewed five prescription charts.

Summary of findings

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, this does not include all of our key lines of enquiry (KLOEs). As a result of this inspection we rated safe, effective and well-led as inadequate, and overall the service was rated inadequate.

We found some improvements from our last inspection. There were continued concerns in relation to requirement notices we served to the trust at our inspection February 2019. Following the focused inspection, we undertook enforcement action in relation to the maternity service, and told the trust it must improve. We issued a warning notice, on the 23 June 2020, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 14 August 2020. The trust initiated an immediate action improvement plan.

The link below is our report published following our last inspection:

https://www.cqc.org.uk/location/RDDH0/reports

Maternity

Inadequate ●

Summary of this service

We rated it as inadequate because:

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately. The service did not always have enough staff keep women safe and to provide the right care and treatment. Multidisciplinary team working was dysfunctional which had impacted on the increased number of safety incidents reported. Incidents were not always graded correctly according to the level of harm and lessons learnt were not being implemented. High risk women were inappropriately giving birth in the low risk area (Midwifery Led Birthing Unit - MLBU). Staff collected safety information, but it was not routinely shared with staff, women and visitors. Care records were not always stored securely. Most of these concerns were raised at our previous inspection February 2019, the service had not improved.
- The service did not make sure staff were competent for their roles. Senior medical staff did not support, supervise and mentor junior medical staff effectively. Staff did not always work well together. Some staff did not feel able to approach some colleagues which was not to the benefit of women and babies. There was poor multidisciplinary presence and structure to the safety handover on the delivery suite and postnatal ward.
- Leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. The service did not have an open culture where staff could raise concerns without fear. There had been a lack of learning from previous incidents and actions put in place were not embedded. We were not assured the vision and strategy of the service was achievable with the current standard of multidisciplinary working within the service.

However:

- The service controlled infection risk well. Staff understood how to protect women from abuse. Staff managed medicines well.

Is the service safe?

We rated it as inadequate because:

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately.
- Multidisciplinary team working was dysfunctional which had impacted on the increased number of safety incidents reported.
- The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.
- The service had enough consultant cover although presence on the delivery suite was poor and responses to emergencies had been inconsistent.
- The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- High risk women were inappropriately giving birth in the low risk area (Midwifery Led Birthing Unit - MLBU).

Maternity

- Staff did not always record and monitor women's carbon monoxide levels in line with the trust policy and saving babies lives (2016).
- The design, maintenance and use of facilities, premises and equipment were not always suitable. The delivery suite birthing rooms were not in line with national guidance.
- Care records were not always stored securely.
- The service did not always manage safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately according to grading and level of harm. Lessons learnt from past incidents were not being implemented by the whole team and the wider service.
- The service did not use monitoring results well to improve safety. Safety information was not shared with staff, women and visitors.

However, we also found:

- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff managed clinical waste well.
- The service used systems and processes to safely prescribe, administer, record and store medicines an improvement from our last inspection February 2019.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Is the service effective?

We rated it as inadequate because:

- We were not assured that the service made sure staff were competent for their roles. There were no effective systems in place to ensure competencies of medical staff.
- Processes to manage staff competency of interpreting cardiotocography (monitoring the fetal heart) had been completed was poor
- Middle grade doctors' competencies were not reviewed, and consultant obstetricians did not support and mentor middle grade doctors appropriately.
- Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. They did not support each other to provide good care.
- The longstanding poor staff culture had created an ineffective multidisciplinary team.
- Annual appraisals had not identified that medical staff had not been competency assessed.

Is the service well-led?

We rated it as inadequate because:

Maternity

- The service leaders did not have the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation. However, staff were positive about the arrival of the interim clinical lead.
- We were not assured the vision and strategy of the service was achievable with the current standard of multidisciplinary working within the service.
- Leaders did not operate effective governance processes to continually improve the quality of its service and safeguarding standards of care. Whilst governance processes were in place these were not fully effective, there remained a lack of oversight and acknowledgment of risk and cultural concerns from the maternity senior leadership team.
- The service did not have an open culture where staff could raise concerns without fear. Staff were very aware of the long standing poor culture and safety concerns.
- There had been a lack of learning from previous incidents and actions put in place were not embedded

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.

The trust set a target of 85% for completion of mandatory training, with the exception of information governance, safeguarding and mental capacity training for which the target was 95%.

A breakdown of compliance for mandatory training courses as of March 2020 for qualified midwifery staff in maternity is shown below:

Training Module name	Eligible Staff	Staff trained	Completion rate
Conflict Resolution	193	175	91%
Mental capacity Act	47	41	87%
Dementia Awareness	193	167	87%
Equality & Diversity	193	126	65%
Fire Safety Yearly (eLearning)	193	153	79%
Fire Safety (Face to Face)	193	123	64%
Information Governance	193	74	90%
Learning Disabilities	159	140	88%
Manual Handling	193	76	39%
Recognition and management of Sepsis - eLearning	192	137	71%
Record keeping - eLearning	190	170	89%

Risk management & incident reporting	193	187	97%
Venous Thromboembolism	174	148	85%
Infection prevention and control	193	178	92%
Adult Basic Life Support	191	127	66%
Neonatal Basic Life Support	190	187	98%

For the reporting period April 2019 to March 2020, the training target was met for eight of the 16 mandatory training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for mandatory training courses as of March 2020 for medical staff in maternity is shown below:

Training Module name	Eligible Staff	Staff trained	Completion rate
Conflict Resolution	19	16	84%
Mental capacity Act	26	21	81%
Dementia Awareness	30	18	60%
Equality & Diversity	30	21	70%
Fire Safety Yearly	30	17	57%
Fire Safety (Face to Face)	30	11	37%
Information Governance	30	27	80%
Learning Disabilities	8	6	75%
Manual Handling	30	24	80%
Recognition and management of Sepsis - eLearning	13	8	62%
Record keeping - eLearning	8	3	38%
Risk management & incident reporting	30	27	90%
Venous Thromboembolism	17	7	41%
Infection prevention and control	30	26	87%
Adult Basic Life Support	19	5	26%
Neonatal Basic Life Support	29	29	100%

For the reporting period April 2019 to March 2020, the training target was met for three of the 16 mandatory training modules for which medical staff in maternity were eligible.

Non-compliance with completion of mandatory training in line with the trust target was a breach identified at the February 2019 inspection and a trust wide requirement notice was issued.

During this focused inspection, mandatory training for staff in the maternity unit did not always meet the trust targets. Following the inspection, the trust executive team acknowledged that there were a number of concerns regarding training compliance within the maternity services and actions were already in place to improve compliance. Due to the

COVID-19 pandemic, all statutory and mandatory training was cancelled for three months in order to release staff to front line clinical duties. The senior leadership (SLT) team told us this had compounded the situation and the improvements the service had planned did not take effect. Following our focused inspection, the SLT informed us that statutory and mandatory training programmes had recommenced to address the poor training compliance.

We raised our concerns and were told that senior leaders were meeting with medical and midwifery staff to ensure that any outstanding training was completed by 17 July 2020. Additional dedicated adult basic life support (BLS) training sessions were specifically arranged for the service to ensure all staff receive an update by the end of August 2020.

Data provided by the service on 20 July 2020 showed 72% of midwifery and 41% of medical obstetric staff had completed their BLS training. The remaining 51 midwifes and 17 medical staff were set to complete their training by the 14 August 2020.

The mandatory training programme was comprehensive and met the needs of the maternity service. Training was provided online learning and at face to face sessions.

The service used nationally recommended 'Practical Obstetric Multi-Professional Training' (PROMPT) to deliver some of the maternity mandatory training. The delivery of PROMPT training was introduced following our inspection February 2019. The topics covered by the PROMPT training included: fetal monitoring, inverted uterus, human factors, sepsis, Modified Early Obstetrics Warning Score (MEOWS) use to identify deterioration in a woman's condition, obstetric haemorrhage (excessive bleeding), shoulder dystocia (an emergency where the baby's shoulders are difficult to birth), breech (baby is birthed bottom presenting), eclampsia (seizures during pregnancy), twin birth and cord prolapse (the baby's cord slips down in front of the baby after the waters have broken). The training was delivered by a multidisciplinary team and involved a mixture of skills and live drills sessions and presentations.

From April 2019 to March 2020, 98% of midwives and 100% of medical staff including obstetric and anaesthetic medical staff completed the PROMPT training.

Data from 18 June 2020 showed that 44% of midwifery and 24% of medical obstetric staff had completed the 'Gestation Related Optimal Weight' (GROW) e-learning, a recommendation from Saving Babies' Lives 2019. Following the inspection, we were told by senior leaders that staff were required to complete the GROW e-Learning by the 31 March 2020. However due to the Covid-19 pandemic a decision was made to suspend the learning. On the 9 June 2020 GROW e-learning training was reinstated and all staff have been given until the 19 July 2020 to complete the training. As of 20 July 2020, 94% of midwifery and 45% of medical obstetric staff had completed the GROW e-learning. The remaining 28 midwifery and medical obstetric staff were set to complete by 30 July 2020.

The trust employed three practice development midwives (PDMs) who were responsible for developing and delivering the mandatory training programme and recording midwifery attendance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training attendance was monitored electronically, and staff received reminders to complete training. Training compliance remained poor, therefore we were not assured that oversight was robust.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Medical staff had not all completed training on how to recognise and report abuse, however they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

Maternity

A breakdown of compliance for safeguarding training courses as of June 2020 for qualified nursing and midwifery staff in maternity is shown below:

Name of course	Number of staff eligible	Number of staff trained	Completion rate
Preventing Radicalisation Basic	193	174	90%
Preventing Radicalisation Awareness	189	165	87%
Safeguarding Adults Level 1	192	181	94%
Safeguarding Adults Level 2	188	119	63%
Safeguarding Children Level 1	241	235	98%
Safeguarding Children Level 2	224	214	96%
Safeguarding Children Level 3	206	196	95%

The trust compliance target was met for five of the seven safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as of June 2020 for medical staff in maternity is shown below:

Name of course	Number of staff eligible	Number of staff trained	Completion rate
Preventing Radicalisation Basic	19	19	63%
Preventing Radicalisation Awareness	19	11	58%
Safeguarding Adults Level 1	15	12	80%
Safeguarding Adults Level 2	30	16	53%
Safeguarding Children Level 1	30	27	90%
Safeguarding Children Level 2	30	27	90%
Safeguarding Children Level 3	23	20	87%

The trust compliance target was not met for any of the safeguarding modules for which medical staff were eligible. The maternity senior leadership team told us that due to the COVID-19 pandemic, all statutory and mandatory training was cancelled for three months in order to release staff to front line clinical duties. Medical staff had been allocated to the next available training sessions.

Midwifery and medical staff received safeguarding training specific for their role on how to recognise and report abuse. The safeguarding training staff received included child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The staff we spoke with could confidently inform us of what a safeguarding concern would be and their process for reporting this. For example, domestic violence cases were some of the issues that had been identified and reported by maternity staff. Staff used the trust intranet safeguarding page to access contact details for further advice or support with safeguarding referrals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were familiar with the process of escalation and referral to the safeguarding specialist midwife for extra support and understood the reporting system for women presenting with FGM. Staff told us they were always able to get support from the lead safeguarding midwife if they needed advice.

Cleanliness, infection control and hygiene

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

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

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service had housekeeping staff who were responsible for cleaning wards and public areas, in accordance with daily and weekly checklists.

Staff cleaned equipment after each contact and labelled equipment to show when it was last cleaned. We saw that there was a system in use throughout the service to identify clean equipment by using ‘I am clean’ stickers.

Infection prevention and control (IPC) audits were undertaken and the results were used to improve IPC practice where needed. From December 2019 to May 2020, the service scored 100% for all elements of the cleaning and decontamination monthly audit.

The service audited hand hygiene and displayed the results in the entrance to the ward area. Data from December 2019 to May 2020 showed that all areas of the service scored 100% in the monthly hand hygiene audit, with the exception of Cedar Ward scoring 90% for December 2019.

The service followed current guidance for infection prevention and control when assessing and caring for women with possible or confirmed cases of COVID-19.

Women with possible or confirmed COVID-19 were cared for in a side room away from other women. We saw good practice when staff attended to these women, they were cared for in single side rooms with appropriate IPC signage and staff wore the correct personal protective equipment (PPE) before making contact.

Staff followed infection control principles including the use of appropriate PPE. We observed staff using PPE which was readily available, such as disposable gloves, masks and aprons.

We observed staff adhered to the trust’s ‘bare below the elbows’ policy to enable effective hand washing and reduce the risk of spreading infections. We observed staff performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public.

Women were screened for Methicillin resistant Staphylococcus aureus (MRSA) at booking. Where inpatient women had a known or suspected infection, they were cared for in single side rooms. There had been no cases of Clostridium difficile (C Diff) or MRSA bloodstream infections in the maternity service from September 2019 to November 2019.

Environment and equipment

The service mostly had suitable premises to care for women. Staff managed clinical waste well.

During our focused inspection the Midwife Lead Birthing unit (MLBU) was closed following an assessment due to escalation of staffing issues, this was in line with the trust policy, therefore we did not visit this area.

The birthing rooms on the delivery suite did not have en suite facilities, which meant women in the delivery suite had to walk past other women, visitors and staff to use any toilet or shower facilities. This was not in line with national guidance (Department of Health (DH), Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities (2013)). The service had plans for the future to improve services however this work was in its infancy.

The service had two dedicated obstetric theatres and recovery area. The neonatal unit was close by if a baby’s condition deteriorated and they required an urgent transfer.

Maternity

In February 2020 the service started a capital build project to increase bed capacity and support care of women in the appropriate setting. This included work to the delivery suite, postnatal ward, the development of the bereavement facilities and a birthing pool on the delivery suite.

Due to COVID-19 pandemic, the suspension of building works had led to some delay with completing the work. However, at the time of our focused inspection six extra beds had been opened, four on the postnatal ward and two on delivery suite.

We were told that work on the bereavement suite improvements would recommence on the 8 June 2020 and would be completed by the end of June 2020 and that work on the birthing pool would commence by the end of June 2020.

During our focused inspection a number of staff told us that they were not involved or consulted in the redesign and layout of the ward area. This was particularly highlighted about the redesign of Cedar Ward. Staff felt the new layout was not workable, for example the desk and administrative space was much smaller and located further away from where the bedded bays were. This meant staff had to either write their notes just outside the bay which did not offer any privacy or take the notes to the desk area some distance away from the women and babies they were caring for.

All areas of the maternity units had card swipe in access for staff and visitors had to ring the buzzer to gain entry or exit. This was an improvement from the last inspection in February 2019 where we were not assured that staff were monitoring who was accessing the ward to mitigate the risk of a baby abduction.

The entrance to each ward was manned by a ward clerk between 9am and 5pm each day and after hours ward staff were responsible for ensuring the correct entry and exit procedure was adhered too. A camera monitor was positioned at the midwifery station which showed who was at the door awaiting entry or exit.

The service had enough suitable equipment to help them to safely care for women and babies. We checked 12 items of equipment and saw that they had up to date safety testing including resuscitaires, weighting scales and sonicaids, which are used to monitor the fetal heartbeat.

Staff carried out daily safety checks of specialist equipment. Staff checked adult and neonatal emergency equipment daily. We reviewed daily checklists for the emergency equipment from 15 April to 12 May 2020 which were all completed.

Staff disposed clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed in sharps containers which were dated and labelled with the hospital's details for traceability purposes. This was in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

Arrangements for the control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials. Staff disposed of clinical waste safely.

Assessing and responding to risk

Staff did not always fully complete risk assessments for each woman. Risk was not always acted upon appropriately.

The Mulberry assessment unit had a designated four-bedded bed and three triage rooms. This provided 24-hour assessment, review and care planning for pregnant women from 16 weeks gestation. Women who visited the assessment unit were triaged by midwives using a traffic light RAG (red, amber, green) rating to see a midwife and/or doctor based on the symptoms they had. We reviewed the notes of seven women who visited the assessment unit, and all were seen within the appropriate time for their RAG rating. This was in line with national guidance (National Institute for Health and Care Excellence (NICE), Safe midwifery staffing for maternity settings overview (September 2019)).

Maternity

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff took all observations required and scored correctly on the 'Modified Early Obstetric Warning Score' (MEOWS) charts. We reviewed 19 MEOWS charts in women's records on the day assessment unit, delivery suite and postnatal ward, we found all observations were completed and scored correctly.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify new born babies at risk of deterioration. At the time of our inspection we reviewed the two available NEWS charts, which were both completed and scored correctly.

Managers told us audits had recently started to assess compliance with the MEOWS guideline. We requested the last three audits and received the audit results and action plans for only one audit in June 2020 the month we inspected. The results showed out of 50 sets of healthcare records which were randomly selected from women who delivered in April 2020; 100% had a MEOWS assessment undertaken on maternity triage and 79% on antenatal admission. The audit also showed that MEOWS assessment was undertaken 12 hourly in only 52% of antenatal admissions and in 66% following birth. However, in postnatal ward, 12 hourly MEOWS assessments were undertaken in 93% of cases. The audit also showed that, nearly 50% of cases were not actioned in accordance with guidance when a MEOWS triggered a score of one or two, the majority of observations were repeated between two or three hours when they should be reassessed every hour. The action plan that was submitted consisted eight actions for the service to complete. The action plan had just been developed in June 2020 the month of our inspection and was yet to be implemented.

Staff used a buddy system to review cardiotocography (CTG) interpretation. This was in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). The service used the 'fresh eyes' approach. This meant a second midwife was required to review the CTG recording hourly during the woman's labour, to ensure it had been interpreted and classified correctly and escalated when needed. We reviewed 12 maternity records which showed CTG peer reviews were performed hourly and were escalated appropriately.

During the focused inspection the maternity senior leadership team told us, in response to the findings from the review of six serious incidents, themes had been identified with misinterpretation of CTGs and where abnormalities had been identified this had not been appropriately escalated. The SLT told us they had taken immediate action, which included; only senior midwives signed off CTG fresh eyes, classifications, and discontinuation. However, staff told us that some senior midwives were not up to date with their CTG training and competencies but signed off CTGs. We escalated our concerns to the maternity senior leadership team and following the inspection we received confirmation that all senior midwives had completed training and been assessed and were competent for CTG interpretation.

Staff did not always complete screening for specific risk issues. For example, we found that carbon monoxide screening which is part of the 'saving babies lives 2016' initiative was not always performed in line with trust guidance. We reviewed 12 records for carbon monoxide monitoring and found that all 12 women's records showed that they were not monitored in line with the trust's policy. Information provided post inspection stated that an electronic system for all antenatal bookings had been introduced in September 2019 and that this had replaced the antenatal booking handheld maternity records. Data provided demonstrated that compliance with testing of carbon monoxide ranged between 90% in November 2019 and 86% in February 2020. This meant the target within the trust guideline that "all women be offered a carbon monoxide screen" was not being met. In addition, having two systems duplicating the same information meant a potential risk of inconsistent and incomplete documentation.

Staff completed booking risk assessments for each woman at their initial booking appointment which included social, medical, obstetric and mental health assessments. This enabled staff to decide if the woman was a high or low risk pregnancy, staff updated them throughout pregnancy, labour and the postnatal period as needed. We reviewed 12 maternity care records which confirmed these details.

Maternity

Women who were assessed as high-risk and unsuitable for the midwife led birthing unit (MLBU) were referred to an obstetrician for review and management. However, following our inspection we reviewed the midwifery led birthing unit births report for April and May 2020 and found high risk women were inappropriately giving birth in the MLBU low risk area. There were three cases in April 2020 and four cases in May 2020 which showed high risk women had given birth in the MLBU. This was an area of concern highlighted in the February 2019 inspection and a requirement notice was issued. We escalated our concerns to the trust executive leadership team and received information that a review of all of the cases in April and May 2020 had taken place. Of the seven cases, three were confirmed as high-risk women and the service had developed an action plan to address the immediate concerns. However, this was yet to be embedded.

Staff completed venous thromboembolism (VTE) assessments of in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein.

We attended a delivery suite safety handover. This was not multi-disciplinary (MDT) attended, there was no representation from the neonatal unit (NICU) or theatres. The format of the handover was not effective, the anaesthetist arrived late, there were several interruptions and on some occasions two conversations were happening at the same time. The handover from the postnatal ward did not follow situation, background, assessment, recommendation (SBAR) format. SBAR is a tool used to facilitate prompt and appropriate communication between wards/services. Senior staff had to prompt staff to give more information regarding the women's history and care plan. Women were referred to by their room number and not their name, which posed a risk if the woman moved rooms or wards.

We reviewed the delivery suite safety handover daily register for week commencing 8 June 2020; on the 8 and 11 June there was no junior doctor present and, on the 10 June 2020, there was no anaesthetist present at the handover. The afternoon medical staff board round from the 8 June 2020 to 10 June 2020 was blank therefore we were not assured that the medical board round was actually held on these dates.

During the morning safety handover, there was no mention of staffing levels, acuity or escalation. On the day of the focused inspection, the Midwifery led birthing unit (MLBU) was closed but this information was not shared. We raised our concerns and following the focused inspection, we were told that the MLBU lead midwife would attend the delivery suite safety huddle at every shift change to update the delivery suite coordinator with regards to all women present on the MLBU.

Midwives did not receive a full handover of all the activities within the delivery suite at the beginning of their shift. Staff told us when they were allocated a woman to care for or if they had to cover for a colleague's break time, they would receive a one to one handover from their colleague. If there was an emergency and urgent cover was needed, the midwife would not have full knowledge of all of the risks and plans of care for all women or the activity on the delivery suite. They would also not be present for the daily safety briefings. This was yet to be embedded and audited as compliant.

There was a pathway for the management of sepsis. Staff we spoke with described what actions they would take if a woman was admitted with suspected or known sepsis including the prompt use of the sepsis six tool, administration of fluids and antibiotics.

Swabs used for vaginal birth and perineal suturing were counted for completeness by two members of staff. This was in line with national recommendations (NSPA, Reducing the risk of retained swabs after vaginal birth and perineal suturing: 1229 (May 2010). We reviewed 12 records and saw two members of staff had verified the swab count.

The World Health Organisation (WHO) surgical safety checklist 'Five Steps to Safer Surgery' was used in maternity theatres. The service carried out observational audit to demonstrate compliance in all sections of the checklist utilised in maternity theatre. The audit measures whether all sections of the checklist are verbalised, exceptions noted and that all relevant staff are fully involved in the process. The WHO surgical checklist maternity observational audit report

showed compliance for the anaesthetist sign out from October 2019 to December 2019 was 36.2% and compliance from January 2020 to March 2020 was worse at 18.3%. Anaesthetist sign out compliance was identified at the February 2019 inspection as poor and a requirement notice was issued. Processes of monitoring improvement have not been effective to mitigate or reduce the omissions.

The service shared an action plan that had been developed to improve compliance. The service planned to re-audit completion of surgical safety checklists in June 2020. During the focused inspection we reviewed seven WHO checklists and found they were fully completed.

Midwifery and nurse staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, to mitigate the risk of harm managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough midwifery staff to keep women and babies safe. Staff told us the delivery suite coordinator was not always supernumerary which meant that in the event that a high number of women attended the delivery suite then they would be providing one to one care for a woman and not facilitating the communication between professionals and overseeing the risk and appropriate use of resources. This was not in line with the 'Safer Childbirth recommendations, October 2007, which states that each delivery suite must have a rota of experienced senior midwives as delivery suite shift coordinators, supernumerary to the staffing numbers required for one-to-one care.'

The service used an acuity tool to identify if the it had the correct number of midwives employed to match the acuity of women accessing the service. Acuity is the measurement used to decide the level of care needed by a woman when in labour and giving birth. The service had conducted a staffing review in 2019 which indicated there was a shortfall of 15.39 whole time equivalent (WTE) registered midwives and 10.98 WTE for maternity support staff. The maternity senior leadership team told us the service was in the process of recruiting midwives.

The managers told us they adjusted staffing levels daily according to the needs of women. The service had an escalation policy which all staff we spoke with were aware of. The policy included calling in community midwives or closing the MLBU in the event of high levels of activity or staff shortages. Staffing was reviewed by managers within the service four times a day.

We saw staffing levels were displayed publicly in all clinical areas for midwives and maternity care assistants. On the day of our focused inspection we found planned staffing levels were mostly met. Although there were staffing shortages managers filled vacancy with bank or agency midwives. The service tried to use midwives familiar to the service all bank or agency midwives had received an induction.

Planned vs actual

The trust reported the following numbers for qualified midwifery staff for June 2020 below for maternity services:

	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing and midwifery staff	193.78	169.18	87.3%

Vacancy rates

As of June 2020, the trust reported an overall vacancy of 20.32 WTE which equated to 10.49% of qualified midwifery staff in maternity. The trust told us that they had recruited 20 WTE midwives who were due to commence their role in September 2020.

Turnover rates

Maternity

From June 2019 to May 2020 the trust reported an overall turnover rate of 6.41% for qualified midwifery staff in maternity. This was lower than the trust target for turnover of 12%.

Sickness rates

From June 2019 to May 2020 the trust reported an average sickness rate of 5.6% for qualified midwifery staff in maternity. This was higher than the trust target of 4%.

Bank staff usage

The service used bank staff to fill gaps in midwifery staff. Bank staff completed an induction programme before working in the service. Ward managers told us they tried to use the same staff to promote continuity of care for women.

From January to March 2020 the service reported 6427 hours were covered by bank midwives.

Medical staffing

The trust informed us that medical staff worked across maternity and gynaecology. For this reason, the data below includes medical staff that work in both core services.

Planned vs actual

The trust reported the following numbers for medical staff for June 2020 below for maternity and gynaecology services:

	Planned WTE Staff	Actual WTE Staff	Fill rate
Gynae Clinical Services	1.00	0.00	
Obstetrics Clinical Services	34.75	30.80	88.6%
Total	35.75	30.80	88.6%

The service had sufficient consultants to cover presence on the delivery suite in line with national guidance 'Labour Ward Solutions (Good Practice No. 10) 2010'. Monday to Friday, consultants were rostered from 8am to 8pm and from 8pm to next day 8am on call off site. At weekends the consultants were rostered for five hours each day and when required to provide offsite on call cover.

During the focused inspection the maternity senior leadership team (SLT) and staff told us there was lack of consultant body support to junior doctors and midwives. Staff told us consultant presence was very poor. The junior members of staff were not comfortable asking consultants for support. In addition, the maternity SLT stated that the consultant body did not feel that it was part of their role to support and teach the junior members of staff. Following the identification of themes from the cluster of six serious incidents the executive team had appointed a new interim maternity clinical director and general manager to ensure clinical presence on the delivery suite improved. Staff spoke highly of this change; however, this had just been actioned in May 2020, we were not assured that this was an embedded practice.

Staff told us that there was a lack of response by consultants to emergencies which meant delays in treating women. An action had been put in place for all consultants to carry bleeps in May 2020. The SLT were monitoring this action, however, this was yet to be embedded and response times were not yet audited.

We escalated our concern to the executive leaders and following our inspection, we received confirmation that a number of changes had been implemented to increase consultant presence on the delivery suite. This included the SLT meeting with the consultant body, reviewing competencies of junior medical staff and supporting them with training. Utilising senior locum medical staff to support the service. All elective caesarean sections would be performed by a

consultant dedicated to an all-day list and not on call for emergencies. This meant that there would be a dedicated consultant that covered delivery suite. In addition, gynaecology and antenatal triage emergencies were going to be managed by a separate consultant from 9 am to 6 pm Monday to Friday. All of these actions had been implemented May 2020, therefore we were not assured that these were embedded, and practices had changed.

Vacancy rates

As of June 2020, the trust reported an overall vacancy of 5.55 WTE, which equated to 15.27% of medical staff working across maternity and gynaecology. The trust reported that the vacancies were in middle grade medical staff posts. Senior leaders for the service told us that they were conducting interviews in July 2020 to recruit into the vacant posts. There were no vacancies in consultant roles.

Turnover rates

From June 2019 to May 2020 the trust reported an overall turnover rate of 2.40% for medical staff working across maternity and gynaecology. This was lower than the trust target for turnover of 12%

Sickness rates

From June 2019 to May 2020 the trust reported an average sickness rate of 2.74% for medical staff working across maternity and gynaecology. This was lower than the trust target of 4%.

Bank and locum staff usage

Locum staff were employed to complete any rota gaps and staff confirmed locum doctors were regularly employed within the service. The service had an induction process to ensure locum doctors understood the process and protocols and to familiarise them with the environment.

From January to March 2020 the service reported 767 hours were covered by bank and 1807 hours covered by locum doctors.

Records

Staff kept detailed records of women's care and treatment, but records were not always completed in line with good practice. Information that was recorded in records was clear, up-to-date and easily available to all staff providing care. Records were not always stored securely.

Staff could access women's records easily. The service mainly used paper-based records, with some information held on the trust's electronic patient record system.

We viewed 12 care records of women who had used the maternity service in the previous 48 hours or whom were still on the ward at time of inspection. The records related to all of the episodes of care during their pregnancy. The records were mostly completed in line with records management code of practice for health and social care. However, records did not always include time of the woman's antenatal appointment this was not in line with the national Nursing and Midwifery (NMC) record keeping guidance (January 2019). This was an issue identified at our February 2019 inspection and a requirement notice was issued to the trust. In addition, staff did not always complete carbon monoxide screening in line with trust guidance. We have provided further detail in the assessing and responding to risk to women and babies section.

During our inspection in February 2019, the completion of women's records in line with trust policy and national guidance was an area identified as a concern and a requirement notice was issued. During this focused inspection some improvements had been made. For example, fetal movements, date of the observation and signature of the member staff undertaking the review were all completed in line with trust policy.

Records were not always stored securely. On the postnatal ward the records were kept in lockable mobile storage trolleys, at the end of each bedded bay. On two occasions during our focused inspection these were left unlocked and accessible to women and unauthorised personnel. Staff we spoke to also stated that this was an issue especially since the changes to the layout of the postnatal ward. Therefore, we were not assured that the service kept women's records secure at all times.

Medicines

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

Medicines were stored securely in all clinical areas we visited. Since the February 2019 inspection Cedar and Willow Wards medicine rooms were moved into purpose built rooms which were compliant with medicine management standards. This was an improvement from our last inspection February 2020.

Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day.

We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within their use by date, including intravenous fluids (fluid given through a vein).

We saw that staff kept records of medicines fridge temperatures and ambient room temperature of their medicine rooms on the delivery suite and postnatal ward.

Secure bedside storage was provided for women's own medicines, which meant women's own medications were stored securely on the wards. This was an improvement from the February 2019 inspection

Staff reviewed women's medicines regularly and provided specific advice to in relation to options of pain relief during and following the birth of their baby. The service had access to pharmacy staff to support the maternity areas.

We reviewed the medicine records for five women and found prescriptions were readable and signed, allergies were clearly documented, and administration and route of administration were also clearly recorded. However, women's weight was not documented in three prescription charts. This is important because the correct dose of some medicines are determined by a woman's weight, such as anti-clotting medicine.

Women at risk of developing a blood clot were prescribed anti-clotting medicine to reduce this risk; the correct dose of which was determined by the woman's weight. However, staff told us they used the woman's booking weight to determine the correct dose which was in line with national guidance (RCOG, Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium: Green-top Guideline No. 37a (April 2015).

Incidents

The service reported safety incidents, staff recognised incidents and reported them. However, we were not assured that incidents were always graded correctly according to the level of harm and if lessons learnt from past incidents were being shared with the whole team and the wider service.

Staff we spoke with 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. Staff we spoke with said they were encouraged to report incidents.

From January 2019 to December 2019, staff reported 1,697 maternity incidents through the National Reporting and Learning System (NRLS). The incidents were graded as having caused no harm (88%), low harm (11%), moderate harm (0.5%), severe harm or death (0.1%). The most common themes for incidents reported were related to treatment and/or procedure (41%), access, admission, transfer, discharge (including missing patient) (13%) and other (22%).

Never events

Maternity

From April 2019 to March 2020 the service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. All potential serious incidents were reviewed by the trust's serious incident panel which met three times a week. If an incident was declared as a serious incident the panel appointed an appropriate senior member of staff to lead the investigation and conduct a root cause analysis (RCA). Incidents which met the reporting criteria were referred to the Healthcare Safety Investigation Branch (HSIB) for independent investigation. The HSIB's maternity investigation programme is part of a national action plan to make maternity care safer. They investigate incidents that meet the 'Each Baby Counts' criteria and maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from April 2019 to December 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	11	85%
Maternity/obstetric incident meeting SI criteria: mother only	2	15%
Total	13	100%

We reviewed the root cause analysis for nine of the 13 serious incidents reported between April 2019 to December 2019. The themes identified included; incorrect interpretation of CTGs and failure to escalate risk from midwife to middle grade doctors and from middle grade doctors to consultants.

The service had a maternal death in February 2019, which was investigated and an action plan produced. The issues identified from the investigation related to: incorrect interpretation of CTGs; failure to escalate risk from the midwives to medical staff; and failure to escalate risk from middle grade doctors to consultants. There were a further six serious incidents reported between January 2020 and April 2020. These serious incidents identified the same failings of care. This demonstrated a lack of learning from previous incidents and actions put in place were not embedded. Therefore, we were not assured that lessons were being learnt to prevent similar incidents from occurring.

We observed that incidents were not always graded correctly. For example, incidents reported on NRLS by the trust from January 2020 to April 2020, a post-partum haemorrhage (PPH) with blood loss of 3000ml, a maternal transfer to intensive therapy unit (ITU) and term babies admitted to the neonatal unit were graded as no or low harm. This meant that there was a risk that women were not informed of the significance of harm caused to them or their baby, or that appropriate action was taken to prevent further occurrences. This was an area that was identified at the February 2019 inspection and a requirement notice was issued.

The trust had an up to date duty of candour policy which staff could access through the trust's intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of

the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with women and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. However, where incidents were not graded correctly there was a risk woman may not receive the correct response, duty of candour and support from staff.

Safety thermometer

Staff collected safety information, but it was not routinely shared with staff, women and visitors.

Safety thermometer data was not displayed on wards for staff and women to see. While managers collected data for the maternity safety thermometer, the results were not displayed.

Managers submitted data monthly to the national maternity safety thermometer. The safety thermometer was designed to support improvements in women's care and experience. Harms associated with maternity were recorded such as perineal trauma, infection and babies with an apgar score less than seven at five minutes. An apgar score is a tool to assess the condition and wellbeing of a baby following birth.

The maternity safety thermometer data from August 2019 to October 2019 showed the service achieved an average of 81.3% harm free care. This was higher than the England average of 76.3%.

Is the service effective?

Competent staff

We were not assured that the service made sure staff were competent for their roles.

At the time of the focused inspection there were no effective systems in place to ensure competencies of staff to interpret cardiotocography (CTG) had been completed. There was poor audit and recognition of staff CTG training compliance and competency assessments following repeated themes identified from serious incidents of misinterpretation of CTG traces.

As a result of the six serious incidents reported between January to April 2020, the service review highlighted concerns about incorrect CTG classifications and lack of escalation which resulted in harm to some mothers and babies. The service decided that only senior midwives were allowed to sign off classifications, discontinuation and hourly reviews of CTG traces.

We raised our concerns with the trust executive team that the senior oversight and staffing on delivery suite could be compromised due to the senior midwives leaving the delivery suite to review CTGs in other areas of the unit.

During our inspection staff told us there were midwives and junior midwives that had completed CTG training and competency assessments, who were no longer allowed to utilise their skills to classify, discontinue or perform a fresh eyes hourly reviews of CTG traces. This decision was based on seniority and not competence of staff and posed potential delays for senior midwives to be able to leave the delivery suite to review CTGs in other areas.

Following the inspection, the trust notified us that actions had been taken to manage and mitigate immediate risk of harm. A masterclass had been booked for all staff to attend and a new competency work book would be completed by all staff. Not all staff had been allocated to attend, we raised our concerns and the executive team responded that more sessions had been arranged and staff in high risk areas would be prioritised to attend first. Training was due to be fully completed September 2020.

The maternity senior leadership team (SLT) told us during our focused inspection that there had been a lack of consultant body support for junior medical staff. Consultant response to an emergency was inconsistent and consultant

presence on the delivery suite was very poor. The junior medical staff were not comfortable asking the consultants for support as they were made to feel incompetent. The maternity SLT said that following a meeting with the consultants in May 2020, the consultants felt it was not their role to support and teach the junior staff. An action plan to address the lack of junior staff supervision and support had been developed by the SLT and was implemented in June 2020. However, the action plan was dependent on the interim clinical director checking consultant presence on the delivery suite daily. In addition, the interim clinical director telephoned the delivery suite every evening to ensure consultant presence at the evening board round and handover; they also checked if the midwives and middle- grade medical staff were happy with the plan of care for women overnight whilst the consultant was on call from home. These actions have only just been put in place, therefore were not yet embedded and audited as compliant.

The SLT told us middle grade doctors' competencies were not reviewed and that the consultant obstetricians did not support and mentor middle-grade doctors appropriately. Following the focused inspection, the executive team informed us that processes were in place to review all middle grade doctors' competencies. As a result, six middle grade doctors had been placed under supervision by senior locum middle grade doctors to ensure they met all of their competencies.

In addition, senior leaders told us that the training director and trainee medical staff had devised an action plan to improve supervision of the junior medical staff, and encouraged the junior medical staff to speak out and raise concerns. This was only implemented in June 2020 and therefore is yet to be embedded.

Staff told us the clinical educators supported the learning and development needs of staff. The service had three practice development midwifes (PDM). The PDM's role included organising mandatory training, inductions for new staff and band five midwives' (junior midwives) preceptorship training. A preceptorship is a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.

Professional midwifery advocates (PMAs) supported midwifery staff to develop through regular, constructive clinical supervision of their work. The PMAs provided group clinical supervision sessions. Staff could also contact a PMA for advice and support when needed, such as if they had been involved in an incident.

The service had staff members who were trained to deliver the Practical Obstetric Multi-Professional Training (PROMPT) approach to obstetric emergency training. The PROMPT team consisted of consultant obstetricians, anaesthetists and midwives.

Appraisal rates

The service met the trust's target of 90% for appraisals between June 2019 and May 2020. Appraisal compliance data for midwifery and medical staff in maternity is below:

Staffing group	Appraisals required	Appraisals Complete	Completion rate	Target met
Qualified Midwifery Staff	192	177	92%	Yes
Medical Staff	30	29	97%	Yes

However due to the concerns raised regarding middle grade doctors' competencies, we were not assured how comprehensive appraisals had been.

Multidisciplinary working

Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. Staff were not always supportive of each other to provide good care.

Staff did not hold regular multidisciplinary handover meetings to discuss women and babies and improve their care. Not all staff necessary in assessing, planning and delivering women's care and treatment were present.

We observed the delivery suite morning safety huddle. This was not attended by all members of the multidisciplinary team. There was no representation from the neonatal unit or theatres. There was some confusion at the beginning of the handover who was leading the discussions. The 'sharing concerns' bulletin was not discussed, a folder was referred to if staff wanted to read them. We raised our concerns to the trust executive leadership team and following our inspection we were informed that neonatal staff and theatre staff would attend, and the sharing concerns bulletin would be read out loud for the multidisciplinary team to discuss.

Staff told us that consultant presence had been inconsistent and that senior medical oversight and supervision and support for the delivery suite team was poor. This history had affected team work and led to difficulty with multidisciplinary decisions being made with high risk cases and emergencies. Following the review of the cluster of incidents from January 2020 to April 2020, a theme identified was there had been a team lack of awareness and appreciation of the roles and responsibilities of others.

Some staff told us that not all consultants and midwives were approachable and accepting of new initiatives and guidance, they were resistant and wanted to continue old practices. Since the appointment of the clinical director May 2020 there had been actions agreed and some improvement, staff welcomed this change. However, this had been recently implemented and was yet to be embedded in practice,

The service held multidisciplinary clinics for women to attend, such as, diabetes clinic which included the diabetic team support.

The anaesthetists held an antenatal clinic for women determined as needing an anaesthetic review. However, staff told us that the clinics were double booked and felt they couldn't give women enough time. Staff told us, since the interim clinical lead started a dedicated anaesthetist was assigned to the elective caesarean section lists on Tuesdays and Thursdays.

There was an enhanced care area within the delivery suite for women requiring extra observations and care. Staff could call for the outreach critical care team for support if they were required. Women who needed level two care (support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care) were transferred to the intensive care unit.

Staff we spoke with said that mental health referrals were dealt with efficiently, in an emergency they would call the obstetric team and mental health team to attend. The service had a vulnerable women midwife to support midwives, women and their families.

Is the service well-led?

Leadership

We were not assured that the service leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation.

Maternity services were within the women's and children's division in the trust's structure. There was a head of midwifery, clinical director and general manager.

At the time of our focused inspection, following the cluster of serious incidents from January 2020 to April 2020 the trust's group clinical director for the three hospitals maternity services had stepped in as an interim clinical director for Basildon hospital. In addition, the service had an interim general manager. Following the inspection, we were informed the trust was reviewing the operating model to bring together management and leadership of services across the three sites. This would then determine any subsequent recruitment.

The head of midwifery (HOM) and the clinical director met with the chief nurse but did not present regularly to the board in line with Spotlight for Maternity 2016. The 'Spotlight on Maternity' March 2016 states 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services, organisations should provide the opportunity for the Medical Director for maternity and the Head of Midwifery to present regularly to the board.' This was an area of concern that was raised at the February 2019 inspection for which a requirement notice was issued.

During our focused inspection, the HOM told us that in the last 12 months she had only presented once to the board. We were told that the chief nurse met monthly with the HOM and clinical director to discuss performance, operational capacity and any concerns. We asked for copies of the last three meeting minutes and found these meetings were held every two months and not monthly. We also noted that the clinical director did not attend two out of the three meetings. The chief nurse also met monthly with all three of the HOM across the trust. We requested minutes of these meetings; however, none were received.

Information provided post inspection outlined that as part of the integration of the corporate governance structures across the group principle assurance committees would meet in common only and retain oversight of performance at individual site level.

We were provided with information that demonstrated papers relating to the maternity service were regularly submitted to the monthly 'quality committees in common', 'site governance forum' and quarterly 'boards in common' meetings. However, direct presentation by either the director and / or head of midwifery was less frequent, occurring quarterly. In the absence of the maternity leadership team presenting to the board the chief nurse would present. However, due to the infrequency of meetings between the chief nurse, head of midwifery and clinical director, where all were in attendance, and lack of minutes from the meetings between the chief nurse and all three HOM we were not assured that concerns were being escalated to the board in a timely manner.

The executive team, maternity senior leadership team, managers and staff reported a longstanding poor culture over a number of years, which had resulted in a deterioration of the safety of the service, and as a result governance and oversight for improved progress and change was not robust. We raised our concerns to the executive team regarding the length of time maternity senior leadership team (SLT) had allowed the culture to continue and were provided with a change in the maternity SLT structure with the appointment of an interim clinical director and general manager from another hospital within the trust and an action plan to address the SLT issues.

Following our focused inspection, the executive leaders acknowledged that culture in the maternity unit needed to be improved and that they had been addressing this since the last inspection in February 2019. In May 2020, concerns for the safety of women and babies were raised by a whistle-blower to the CQC. During our focused inspection, the SLT told us the poor culture had been present for numerous years. Therefore, we were not assured sufficient steps had been taken to address the culture issues prior to the interim clinical director and general manager's appointment. Whilst actions and change of processes to improve culture were implemented in May 2020, this was still in its infancy and yet to be embedded.

The new SLT also told us that there had been a lack of leadership oversight of the consultant body's support for junior medical staff. The junior medical staff found it difficult to approach and escalate risk to some of the consultants for support as they were made to feel incompetent. An action plan to address the lack of junior staff supervision and support was developed by the maternity senior leadership team and was implemented in June 2020. However, the action plan was dependent on the interim clinical director checking consultant presence on the delivery suite daily. In addition, the interim clinical director telephones the delivery suite every evening to ensure consultant presence at the evening board round and handover; they also checked if the midwives and middle grade medical staff were happy with the plan of care for women overnight whilst the consultant is on call from home. At the time of our focused inspection, these actions had only been put in place, therefore were not yet embedded.

Staff spoke positively about the arrival of the interim clinical director. The head of midwifery and interim clinical director told us that they worked well together and were supportive of each other. However, we were not assured around the long-term sustainability and impact of the action plan as it appeared heavily dependent on one person checking behaviours. Following the inspection, the executive team told us that substantive changes were being made including the appointment of a director of midwifery, and the implementation of a revised group model for maternity risk and governance management for long term sustainability.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust developed a five year strategic plan following the recent merger of Basildon University Hospital with Mid Essex and Southend University Hospitals to form Mid and South Essex NHS foundation Trust. The maternity service strategy was included with the trust's five year strategy.

The maternity service's strategy detailed the service's ambitions for the next five and was aligned to the local maternity board (LMB) strategy. The strategy spoke of close collaborative working with the LMB throughout. We did not see an action plan in place with actions assigned to individual staff members, to achieve the strategy.

The maternity service has its own vision of "working in partnership with women, empowering them to make informed decisions about their care, ensuring that it is personalised to meet their individual needs." Staff did communicate and plan care with the women individually, however, due to the concerns raised throughout our inspection we not assured that this was always achievable with the current standard of multidisciplinary working within the service.

Culture

The service did not have an open culture where staff could raise concerns without fear.

All staff we met during our inspection were welcoming, friendly and helpful. It was evident that staff were concerned about the recent cluster of serious incidents and wanted to improve the care they provided to women and babies. However, staff were very aware of the longstanding poor culture and safety concerns. They expressed to us the impact the longstanding poor culture had impacted on women and babies care and staff morale. Staff told us that some of the consultants and longer serving midwives were difficult to approach and support from medical staff was a struggle.

In May 2020, concerns for the safety of women and babies were raised by a whistle-blower to the CQC. During the focused inspection both staff and maternity senior leadership team (SLT) told us the poor culture had been present for a number of years. Although a new maternity SLT were in place from May 2020 actions to improve the long-term history of poor culture and ineffective multidisciplinary team working which had impacted on safety in the maternity unit, were in their infancy and not yet embedded. Therefore, we were not assured sufficient steps had been taken to address the culture issues prior to interim clinical director's appointment and our focused inspection.

All NHS trusts are required to nominate a freedom to speak up guardian (FTSUG). The role of the FTSUG supported staff who wished to speak up about a concern or issue and ensured that any issue raised was listened to and the feedback was provided to them on any actions or inactions because of them raising an issue. Most staff we spoke with were aware the trust had a FTSUG service and how to report their concerns if required.

In the last 12 months, FTSUG service had received three enquiries in relation to the maternity service. We were told that none of the concerns raised were in relation to safety. The SLT told us that following our inspection they will be raising staff awareness of the FTSUG service.

Maternity

The trust executives told us that in May 2020, it was decided to bring in a new leadership to the maternity unit to support and develop an action plan to address the safety culture. The interim clinical director initiated daily safety calls on delivery suite and weekly meetings with the consultants.

Following our concerns raised to the executive team we received an action plan to improve the culture which contained the following for example: establishing regular staff forums, the development of a communication strategy to encourage staff to escalate concerns and involving external stakeholders for cultural support. However, these are all in their infancy and are not yet embedded.

Governance

Leaders did not operate effective governance processes to continually improve the quality of its services and safeguarding standards of care.

Whilst governance processes were in place these were not fully effective, there remained a lack of oversight from the senior leadership and executive team. A number of the issues identified during our focused inspection, were pre-existing issues that had already been highlighted at the February 2019 inspection. Requirement notices were issued in relation to these breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust developed an action plan in response to these breaches, submitted regular updates and closed the actions, however, we found at our focused inspections the concerns were still present. The actions put in place did not address or remedy the issues and the maternity governance did not identify issues with the quality of care being provided. The systems and processes that were in place to address the concerns from February 2019 had still not been embedded within the service.

The maternity service had a maternal death February 2019, which was investigated by HSIB and an action plan produced. The issues identified related to: incorrect interpretation of CTGs; failure to escalate risk from the midwives to medical staff; and failure to escalate risk from middle grade doctors to consultants. There were a further six serious incidents reported between January 2020 and April 2020. Five of these serious incidents identified the same failings of care. This demonstrated there had been a lack of learning from previous incidents and actions put in place were not embedded. Therefore, we were not assured that the governance and oversight of lessons learnt was robust enough to prevent similar incidents from occurring.

The head of midwifery (HOM) did not have direct access to the board and did not present to them regularly in line with ‘Spotlight on Maternity’ 2016. This was an area of concern that was raised at the February 2019 inspection for which a requirement notice was issued. The governance systems were not effective to ensure appropriate escalation, scrutiny and overall responsibility at board level.

We found concerns relating to the governance processes of incident grading and appropriate review. This was an area that was identified at the February 2019 inspection, for which a requirement notice was issued. Incident data reported by the trust from January to April 2020, demonstrated that incidents were not always graded correctly in accordance to moderate harm as stated in Regulation 20 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

The service had a formal governance structure in place. The maternity service was within the

women’s and children’s division. The clinical maternity governance and risk manager held responsibility for managing risk within the maternity services, including monitoring incident reports, compliance with learning outcomes, and actions resulting from serious incident reviews.

At our focused inspection we found a number of areas of concern within the structure of the maternity governance and risk management team. The clinical governance lead role was vacant. As an interim measure the clinical governance lead from paediatrics and gynaecology had been providing support to maternity and at the time of our focused inspection they had returned to their substantive role.

Maternity

At the time of the focused inspection there were a number of overdue investigation reports, action plans and open incidents. Information received from the trust following the focused inspection showed three serious incident investigations that were overdue (over 60 days), nine internal root cause analysis overdue, 11 external report recommendations overdue to be developed into action plans and/implemented, and 27 serious incident action plans overdue for closure. This meant the governance systems and processes in place were not robust to ensure timely review of incidents and sharing of lessons learnt.

Following the focused inspection, we were told that a group wide maternity governance and risk management structure had been developed. This was subject to a staff consultation, before it could be implemented.

The service held monthly clinical governance meetings. We requested the last three meeting minutes and we were provided with the minutes from November 2019, January 2020 and May 2020. We were not assured on the frequency and regularity of these meeting to monitor risk and governance within the service. In addition, the minutes showed that the head of midwifery was not present at any of the meetings and the risk lead for maternity was only present at the November 2019 meeting. We reviewed the meeting minutes which confirmed governance matters such as incidents, risks, performance, guidance, audits and complaints were discussed, however not all actions were clearly assigned to a member of staff with a deadline for completion.

The service held perinatal mortality and morbidity meetings. Following our focused inspection, the executive team told us that the interim clinical director had reviewed some of the cases discussed by the perinatal review group and had raised concerns about the decisions made by the group and sometimes the group was not quorate and hence the discussions and decisions would not be valid. Senior leaders confirmed that they had taken urgent actions and put new measures in place to address the concerns raised; by reviewing all the cases discussed since January 2020, and a review of the terms of reference of the perinatal mortality and morbidity review group.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively.

There were some processes in place to identify risk. The maternity service had a risk register and we saw that risks within the service were on the risk register. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We observed the risk register and risks were in date and had been reviewed.

The service had reported compliance to the board and NHS resolution for safety action six compliance with the saving babies lives initiative 2016. However, from our review of the 12 maternity handheld records the service were not always monitoring carbon monoxide in line with the trust guidance in all of the records. Therefore, they were not compliant with the saving babies lives initiative 2016. Information provided post inspection stated that an electronic system for all antenatal bookings had been introduced in September 2019 from which reports were generated to monitor compliance. Data provided demonstrated that between November 2019 and February 2020 compliance was 90%, 86%, 88% and 86% respectively. Carbon monoxide testing should be offered to all pregnant women at the antenatal booking appointment with the outcome recorded (Saving babies Lives Care Bundle Version 2 2019). We were not provided with any additional evidence to provide assurance that this was regularly audited and reviewed or that actions had been taken to improve compliance.

Daily handovers included a briefing of any issues highlighted by managers. However, we observed that the handovers were not detailed, and qualified midwives did not attend the whole handover. Therefore, not all would not be aware of the risks discussed.

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 dashboard was not displayed in clinical areas, this meant that staff and the public were not informed of the outcomes and risks of the maternity service.

Maternity

We saw that the services dashboard was reviewed as part of the women's health clinical governance & risk group meeting. We requested the meeting minutes for these and reviewed three sets from November 2019, January and May 2020. We saw that the meetings also discussed incidents, complaints, guidelines, the risk register, and audits, however not all actions were clearly assigned to a member of staff with a deadline for completion.

Areas for improvement

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

- The service must complete carbon monoxide screening in line with trust policy. Regulation 12 (2) (a)
- The service must ensure staff completed mandatory and safeguarding training with the trust target. Regulation 12 (2) (a)
- The service must ensure that the delivery suite daily handover is fully attended, situation, background, assessment, recommendation (SBAR) format is used for all women, they are referred to by name and the afternoon board round is attended and documented. Regulation 12 (2) (b)
- The service must ensure the delivery suite coordinator is always supernumerary. Regulation 12 (2) (b)
- The service must ensure multidisciplinary team working is improved. Regulation 12 (2) (b)
- The service must ensure that the medical staff competencies are reviewed and up to date. Regulation 12 (2) (c)
- The service must ensure that appraisals are comprehensive and assess staff competencies. Regulation 12 (2) (c)
- The service must ensure that all records are kept securely. Regulation 17 (2) (c)

Action a trust SHOULD take is 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 weights are documented on prescription charts.
- The service should display safety information.

Our inspection team

The team that inspected the service comprised an of inspection manager, a lead inspector and specialist advisor. The inspection team was overseen off site by Mark Heath, interim Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Section 29A HSCA Warning notice: quality of health care