East Suffolk and North Essex NHS Foundation Trust

Colchester General Hospital

Inspection report

Turner Road
Colchester
CO4 5JL
Tel: 01206747474
www.colchesterhospital.nhs.uk

Date of inspection visit: 07 April to 15 April 2021
Date of publication: 16/06/2021

Ratings

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

Our findings

Overall summary of services at Colchester General Hospital

Requires Improvement 

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) provides both acute hospital and community health care and was formed on 1 July 2018 following the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust. ESNEFT maternity consists of services at Colchester, Ipswich and Clacton.

At Colchester General Hospital, the delivery suite consists of eight birthing rooms with two fully equipped co-located obstetric theatres to support consultant-led care and a four bedded midwifery-led birthing unit for women identified as low risk of complications. The maternity ward has 26 beds and accommodates both antenatal and postnatal women. Specialist antenatal clinics are provided for women with diabetes, vulnerable women birth choices and a specialist obstetric scanning service. In addition, specialist midwives for safeguarding, bereavement, clinical effectiveness, practice development, antenatal, newborn screening and infant feeding work within the multi-disciplinary teams. Ultrasound is provided at Colchester and Ipswich sites including fetal medicine specialist services.

From March 2020 to March 2021 there were 3656 deliveries at Colchester General Hospital.

We last inspected the maternity service at Colchester General Hospital between the 11 June and 18 July 2019. The report was published on the 8 January 2020. The maternity service was rated good for all five domains.

We carried out this unannounced focused inspection of maternity services following emerging concerns in relation to staffing, incidents, leadership and culture. Between August 2020 and February 2021, we received six concerns raised by whistle-blowers in relation to midwifery staffing levels impacting on women's safety, affecting care pathways, and having a negative effect on staff wellbeing. In addition, we received concerns about leadership communication, competence, visibility and support as well as concerns about the safety and quality of the services from people who used the service.

We did not inspect Clacton Maternity Unit as part of this inspection.

How we carried out the inspection

As part of this inspection we visited the following areas within the maternity services; maternity triage, consultant led delivery suite and post-natal ward. We spoke with 21 members of staff including medical and midwifery staff, maternity support workers and service leads. We observed care, handovers/meetings and reviewed 10 sets of maternity records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information about this service.

Focused inspections can result in an updated rating for any key questions that are inspected if we have identified a breach of regulation and issued a requirement notice. In these cases, the ratings will be limited to requires improvement. Because of this, there were changes to ratings for maternity services in safe and well-led, giving an overall rating of requires improvement for maternity services at Colchester Hospital.

Our rating of services went down. We rated them as requires improvement because:

Our findings

- Sustained periods of reduced staffing and issues with the management of the maternity triage system and the process for induction of labour impacted on staff wellbeing and their confidence in keeping themselves and women and babies safe.
- Staff were not always compliant with important training, for example, sepsis and safeguarding training to protect women from harm or abuse. Medicines where not always stored correctly and there were gaps in emergency equipment checks.
- The service had been without a clear strategy with aligned governance processes. Staff were unclear about their roles and responsibilities as a result. Staff did not always feel respected, supported and valued by the trust and the leadership teams.
- The was a lack of oversight from the trust board and the senior leadership team, with delays in managing and implementing timely actions despite the known ongoing concerns relating to many of the issues highlighted above.

See the Maternity Services section for what we found.

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

Maternity

Requires Improvement

- The service did not always have enough staff to care for women and keep them safe. The maternity triage system was overburdened and the pathway / process for induction of labour was not effectively managed. Longevity of sustained staffing shortages were impacting on the wellbeing of staff and safety of women.
- Medical and midwifery staff did not always have up to date safeguarding training to help them understand how to protect women from abuse and manage safety well. Medicines were not always stored correctly. The service did not control infection risk well; we found issues in relation to furniture and clinical waste and there were gaps in emergency equipment checks.
- Leaders did not always run services well. Staff did not have access to a clear strategy with aligned governance processes. Staff were not all familiar with the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported and valued by the trust and the leadership teams. Staff were not clear about their roles and responsibilities.
- There had been significant change in senior leadership which had led to an instability in the team with a gap in accountability and ownership. Leaders were not making a demonstrable impact on the quality or sustainability of services. Governance structures, processes and systems of accountability were unclear to staff. Levels of governance and management did not function effectively.
- Staff recorded safety incidents; however, some incidents were graded as no harm thereby potentially missing the opportunity to review the incidents in greater detail and improve practice.

However:

- Staff provided pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Is the service safe?

Requires Improvement

Mandatory training

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

Staff received mandatory training, however there was no statutory or mandatory training undertaken between March and June 2020 due to the Covid 19 pandemic, with the exception of basic life support and neonatal life support. Due to the challenge of suspended learning during the pandemic surge periods, managers put a plan in place to provide training to staff to meet the March 2021 completion deadline. Staff training was encouraged, supported and provided via eLearning and face to face learning sessions.

The mandatory training was comprehensive and met the needs of women and staff. 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.

Maternity

Mandatory training included Cardiotocography (CTG), a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy, and Practical Obstetric Multi-Professional Training course which covered the management of a range of obstetric emergency situations; staff achieved 98% compliance.

Overall staff compliance for mandatory training courses as of March 2021, for the total 157 qualified midwifery staff in maternity, met the target of 90%, however there were two important exceptions. Compliance for maternal sepsis was only 34% and growth assessment protocol (GAP) to understand measuring fetal growth training was 77% which was not in line with local policy. At the time of inspection there had been no increase in related safety incidents however low staff training compliance might mean some staff did not have the key skills in those areas to keep people safe. We found that fetal growth was not recorded appropriately in seven of the 10 women's records we reviewed during the inspection. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction is part of the national guidance (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)).

Following our inspection, we reviewed the Antenatal Care and the Detection and Assessment of Fetal Growth Restriction Guideline, version 1, dated 13 March 2020. This outlined that all midwives and obstetricians will undertake Perinatal Institute e-learning and competency, with an annual maternity statutory training face to face GAP update.

There was an Intrapartum Fetal Heart Rate Monitoring guidance document in place, version 8, that detailed the appropriate fetal monitoring for women in labour which staff could refer to.

Safeguarding

Staff understood how to protect women from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it, however training compliance of medical staff was low.

Not all staff were up to date with their training, specific for their role, on how to recognise and report abuse. The trust told us all safeguarding training was suspended during the first and second Covid-19 surges and level 3 safeguarding had been switched to virtual instead of face to face training.

The trust set a target of 95% for completion of safeguarding training. The overall compliance for completion of the safeguarding level 3 training for Colchester maternity service staff was 82% which meant 146 of the 178 staff had completed their level 3 safeguarding training. We found there was a drop in the level of training compliance for medical staff. Twenty of the 35 medical staff had not completed their safeguarding level 3 training whereas 131 of the 143 midwifery staff had completed their training. This meant there were a significant number of medical staff who were not trained to the level required to help keep people safe.

However, staff understood how to protect women from abuse and raise safeguarding concerns. Women's records showed that several safeguarding questions were raised at assessment stage. Women's records showed the national enquiry question about domestic abuse was asked antenatally. Staff asked mental health questions in a sensitive way at assessment.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Maternity

Ward areas were not visibly clean or have suitable furnishings which were clean and well-maintained. Chairs in the corridor did not meet required standards. They were covered in fabric with tears and holes and were not wipeable. This meant they could not be appropriately cleaned and could risk the spread of avoidable infections.

Cleaning records were not always up to date to demonstrate that all areas were cleaned regularly. We looked at cleaning records and saw there were gaps in the checklists, for example, signatures to evidence the completion of cleaning. We saw that some of the areas and equipment were dusty and some areas were untidy with overflowing bins. This might increase the risk of the spread of infection.

We were not assured that regular personal protective equipment (PPE) audits were taking place. We requested data, from October 2020 to March 2021 for infection control audits in relation to surgical site infection, PPE, handwashing, MRSA and C-Diff. We received hand hygiene audits for the six months, across all three areas (post-natal ward, triage and delivery). Although the sample sizes were small the data demonstrated 100% compliance.

However, other audit data was limited to only one PPE audit, dated March 2021 with overall compliance at 91.5%. It was stated in the submission that the surgical site infection audit was under review and no further information was supplied with regard to MRSA or C-Diff. Therefore, we could not be assured that these audits had been taking place. We requested the local audit programme however no specific infection control audits were included.

Environment and equipment

Staff did not always manage clinical waste well and checks of specialist emergency equipment were not consistent. The design, maintenance and use of facilities, premises kept people safe.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed daily checklists for the emergency equipment for the month of March; six of the 30 were incomplete. The head of midwifery shared with us that there was a drive on improving compliance by completing regular matrons' audits. We saw evidence of audits alongside actions and learning from those audits to promote positive change.

Staff did not always dispose of clinical waste safely. Separate colour coded arrangements for general and clinical waste were in place, however we saw bins overflowing and without lids. This could raise the risk of infections. Sharps, such as needles, were disposed in sharps containers which were dated and labelled with the hospital's details for traceability purposes. However, sharps bins were not appropriately stored off the floor.

Arrangements for the control of substances hazardous to health (COSHH) were not always adhered to. Cleaning equipment should be stored securely in locked cupboards however we saw a container of hazardous fluid left near the sink. This meant unauthorised persons could access hazardous cleaning materials.

Staff did not always store equipment safely. We saw the pre-eclampsia box in a public corridor that was not locked. Staff left medication/IV fluids such as Saline and anaesthetic gels in the corridor. This meant a risk that they could be accessed by unauthorised people.

The midwife led birthing unit (MLBU) consisted of four birthing rooms and three pods. This had been converted to a Covid-19 isolation area from January 2021 to March 2021. There were two rooms on the delivery suite where water births could still be offered as an option. Midwives worked in the area on their own, however it was next to the delivery suite and had easy access to doctors in emergency. Call bells in the MLBU rang in the delivery suite and the midwife we spoke with told us they did not feel isolated.

Maternity

Visitors accessed the maternity unit by ringing the buzzer to gain entry or exit. Authorised staff were issued with swipe cards to access to the unit to ensure the area was secure.

Assessing and responding to patient risk

The maternity triage system was overburdened and the pathway / process for induction of labour was not effectively managed. The structure of shift changes and handovers were not consistent. This meant a potential risk of delayed treatment.

Shift changes and handovers were not always structured to ensure all necessary key information was shared to keep women and babies safe. We observed morning handovers with medical staff and multi-disciplinary teams. One morning handover was busy with lots of interruptions, people were seen to walk in and out throughout the conversation. The handover lacked structure and there was no clear format to ensure clear and specific exchange of important detail. This might mean important detail was not shared with the right people and had the potential to put women at risk.

The maternity triage system was overburdened and therefore a risk to women's safety. The system had too many functions including; managing a telephone helpline, performing pre-op assessments, and managing routine and emergency attendances. This risk was further exacerbated by a significant lack of appropriate staffing.

The maternity triage room was supported by maternity staff and accessible to women from 16 weeks gestation, 24 hours a day. The unit was supported by an obstetric team, who were available to review women once they had been assessed and triaged by the midwives. Women could self-refer when they had concerns regarding fetal movements. Maternity triage also provided outpatient appointments for women having follow-up care on an individual basis for example, raised blood pressure and anaemia. Staff were also responsible for answering all calls from women with concerns, carrying out face to face assessment and directly referring to the delivery suite. Staff in triage assessed women using a red, amber, green (RAG) rating system. Triage staff had a number of responsibilities when the women attend including recording mid-stream urine samples and blood tests. They undertake a full antenatal examination and The Maternity Early Obstetric Warning System (MEOWS) observations. Depending on clinical need blood tests may be taken.

The trust reported incidents on the national reporting system. Prior to inspection there had been several incidents that indicated excessive workload and delays in women being seen in triage area. There were 24 red flags at Colchester from December 2020 to March 2021: the most common reasons for the red flags were delays in induction and missed or delayed care. In one case three women had to have their appointments rescheduled. In one case, a three-hour wait was documented due to lack of staff and capacity. This could have impacted on clinical care, the wellbeing of the women attending triage and overall satisfaction of people involved, including staff.

Staff shortages and acuity, from 7 March until 8 April 2021, meant there was a decline of 24% in in-utero transfers. There was a delay in accepting transfers under two hours of 17%. There was a significant delay in commencing induction of labour (as per trust guideline) of 59% all of which could impact on women's safety.

Staff did not always manage the induction of labour process and pathway effectively. The process was not robust as there was no clear booking pathway. Staff from across the service used a handwritten booking system to amend and cancel inductions. Staff told us the book was regularly taken from the triage workstation and could not always be conveniently located. Staff told us it was often amended which caused confusion, had the potential for errors and added to their stress. The lack of formalised booking meant there was no way of knowing exactly how many women would be arriving for induction on any given day. This impacted on the ability to pre-plan and organise appropriate staffing, which could result in unnecessary delays, women's safety risks and decreased satisfaction.

Maternity

The Royal College of Obstetricians and Gynaecologists (RCOG) Assisted Vaginal Birth Guidance, April 2020, outlines when attempted forceps delivery should be discontinued and second opinion sought. Staff reported a serious incident in October 2020. The serious incident highlighted concerns with prolonged second stage of labour, instrumental delivery and delayed senior clinical review. Having reviewed the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) databases we found that there had been similar incidents reported as either low or no harm where forceps delivery and prolonged second stages of labour were noted.

Staff completed up to date risk assessments for each woman and took action to remove or minimise risks. We reviewed the notes of 10 women who visited the triage area, and all were appropriately assessed, seen at the right time and escalated based on their RAG rating.

Staff took all observations required and scored correctly on the 'Modified Early Obstetric Warning Score' (MEOWS) charts. We reviewed 10 MEOWS charts in women's records on the day assessment unit and postnatal ward, we found all observations were completed and scored correctly.

Staff knew about and dealt with any specific risk issues. We looked at 10 women's records and all women had venous thromboembolism (VTE) assessments. Staff completed VTE assessments in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein. Women had 'fresh eyes' if CTG was performed. This was in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). A second midwife, using the 'fresh eyes' approach meant the CTG had been reviewed by a different midwife to ensure it was correctly interpreted and escalated if appropriate.

There was an escalation policy in place that had been updated just prior to our inspection. We reviewed the Escalation policy, version 2, 18 March 2021 which clearly outlined actions to be taken and how staff could escalate increasing risk.

Staff used Local Safety Standards for Invasive Procedures (LocSSIPs) alongside an updated standard Operating Procedure (SOP) for maternity LocSSIP. This was a checklist to reduce the number of patient safety incidents related to invasive procedures in which never events could occur. There was an updated SOP circulated to stakeholders including consultant obstetricians, senior co-ordinators, maternity managers, and the chairs of the trust invasive procedures oversight group. Staff carried out audits of the LocSSIP and found that the checklist was not fully embedded into practice. We saw that the SOP had been updated and improvements made as a result of feedback from staff using it and feedback from audits.

The World Health Organisation (WHO) and five steps to safer surgery checklist is used to facilitate patient safety policy and practice in operating theatres. In maternity staff audited its use monthly to demonstrate compliance in all sections of the checklist and measure overall compliance. Data provided demonstrated that between April 2020 and February 2021 overall compliance ranged between 92% and 100%

However, when we looked at audits of compliance with risk assessments and safety monitoring, we saw that there were several omissions that could impact on wellbeing of both women and unborn child. For example, we reviewed intrapartum fetal monitoring audits from November 2020 to March 2021. Each month demonstrated non-compliance; admission risk assessment in labour was not always completed and 'fresh eyes' reviews were not always carried out in a timely way. This was not in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). However, staff who carried out the audits reported on themes, identified overall actions performed with dates of completion and recorded ongoing actions. This meant where they had identified non-compliance, they took action to improve practice and reduce errors.

Maternity

Leaders had developed a standard operating procedure (SOP) to increase support for at risk pregnant women of black, Asian and minority ethnic (BAME) backgrounds. All midwives, obstetricians and the multidisciplinary team in maternity were to use this guidance document which was produced in November 2020. The SOP detailed the steps required to support women and pregnant people from BAME backgrounds to reduce risk and ensure appropriately planned care. Staff told us the key principles and how the guidance should be applied messages were communicated by leaders. Staff we spoke with were aware of the SOP which at the point of inspection had not been formally implemented.

Midwifery and nurse staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. To help mitigate the risk, managers regularly reviewed and adjusted staffing levels, reallocating staff from other areas and recruitment was ongoing.

The service did not have enough nursing and midwifery staff to keep women and babies safe. Prior to the inspection we had received information from six whistle-blowers raising concerns over staffing within maternity. We found on inspection that the number of midwives and healthcare assistants did not match the planned numbers. Staff at all levels told us there was a consistent lack of maternity staff.

Managers calculated and reviewed the number and grade of midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels could be adjusted according to the needs of women. Midwives carried out an hour by hour assessment to determine staffing needed in the delivery suite to meet the needs of the women. This was based on the minimum standard of one to one care for all women in active labour and increased ratios of midwife time for women in the higher need categories. However, qualified staff were not always available. Staff told us that they could not always cover every shift.

Managers provided us with staffing data for November and December 2020. Actual midwife staffing numbers were below template for early, late and night shifts on all but one day.

Midwife staffing numbers were three below template on 10 days in November. In December 2020, planned midwife staffing numbers were two or more midwives below template on early, late and night shifts on 26 days. Planned staffing were two or more below template (13 midwives) on 16 days in January 2021. This meant that staffing was consistently low during this period and had a potential to impact on women's safety.

Planned versus actual data from January to March 2021 demonstrated a consistent lack of staffing across the neonatal and in-patient unit. January aggregated fill rates on a day shift for qualified staff were 89% and 88% for unqualified staff. January aggregated fill rates on a night shift for qualified staff were 88.3% and 84% for unqualified staff. Similar figures were provided for February and March 2021, ranging from 70% to 87% fill rates. All of which fell short of the nursing staffing levels fill rate versus template. This confirmed the whistle-blower information that we had received raising concerns around prolonged staff shortages, staff being mentally and physically strained, with poor support from senior management and women's safety concerns becoming more frequent.

Midwives used the National Institute for Health and Care Excellence (NICE) endorsed acuity tool. Acuity is the measurement used to decide the level of care needed by a woman when in labour and giving birth. The tool captured

labour ward, midwife led unit and their antenatal/ postnatal ward activity. The tool could be used in real time in the delivery suite to assess how many midwives were needed to safely support the numbers of women needing care. This included a review of their condition on admission and during the processes of labour and delivery. Compliance with the labour ward tool was approximately 70%.

We requested audits on National Institute for Health and Care Excellence (NICE) Clinical Guideline 190 (1-1 care in labour) however these were not provided; the trust told us that the data has been collected and was in the process of being analysed. This meant we were unable to determine whether they were compliant with NICE guidance to keep women safe by providing appropriate one to one care during active labour.

Specialist midwives and ward managers told us, and we saw evidenced in records, that they were working clinically to backfill staffing shortages. For example, records showed that these staff worked on seven days in November and four days in December. Staff were reallocated from their rostered clinical area on nine days in November and three days in December 2020.

To help address the staffing shortages there had been a rolling recruitment drive and 16 new midwives had been recruited with start dates pending. This had helped reduce the service vacancy rates from 8% in March 2020 to 4% in February 2021. The service annual turnover rate was 6.9% in March 2021.

The service did not use agency midwives to cover staffing shortages in the service. Managers used bank staff, of which there was just one from 7 March until 8 April 2021. Four staff stayed beyond their rostered hours during this period. This meant they were using their own staff to cover extra shifts were possible. This had benefits in that the staff were already familiar with the service, however this also increased work schedules for staff which meant they may become burnt out and less effective in their roles.

In addition to the staff vacancies, staffing numbers were further impacted due to high sickness rates. Unexpected midwife absence/sickness from 7 March until 8 April 2021 was 33%, during this period 57% of vacant shifts were not filled. 7% of midwives were redeployed to another area, support staff were 4% less than rostered numbers. There was a risk that staff redeployed from other areas may not have full skills and competency required to ensure safe care of women. Staff told us that the sustained staffing shortages impacted on their stress levels and ability to provide safe, good quality care and reported work related stress and burnout. However, on the day of inspection, we saw that staff worked well together to focus on the needs of women receiving care on the day of the inspection.

Staff regularly reported staffing concerns in the incident reporting system. We saw examples when care had been compromised as a result of staff shortage. For example, we looked at 24 maternity red flags where staffing difficulties resulted in delays in transfer to delivery suits, delays in caesarean section and delays as there was no available obstetric medical staff available.

We asked the trust to provide us with the number of diversions they had in the last twelve months. From March 2020 to October 2020 the trust had diverted women due to staffing and acuity on four occasions. From February to March 2021 there had been an increase in diversions as a result of staffing and acuity. On one date in February the trust reported very low staffing; six below template.

Medical staffing

Maternity

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe. A consultant for the labour ward was available weekdays and in addition there was an on-call consultant accessible when needed. An on-call consultant and labour ward consultant were available at the weekend.

The medical staff matched the planned number.

Medical staffing had improved in the past 12 months. This was due to a recent round of trainees, with a full complement received in August 2020. Some of the trainees had left due to fellowships and Certificate of Completion of Training which legally permit its holder to work in NHS general practice. There were no rota gaps and there were new starters from February 2021. The service employed 12 consultants and 12 were in post. There were some gaps due to sickness; one of which was long term sick and one middle term sick.

The service employed bank and locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, up to date, stored securely and easily available to all staff providing care.

Women's notes were not always comprehensive. Staff could access electronic records easily and securely, however some women's records were handwritten which meant they did not have the same ease of access. Handwritten notes were not in an easily assessible order which meant staff may have difficulty in efficiently accessing information when needed.

We reviewed a total of 10 women's records. Whilst these were partially completed in line with records management code of practice for health and social care, there were some gaps that could impact on the safety of women and unborn baby. For example, seven of the ten records we reviewed did not have fetal growth plotted on the fetal growth chart and four of the ten records did not have fetal movements recorded each antenatal visit from 25 weeks.

Records were stored securely. Staff could access women's electronic records using a secure password. Handwritten records were kept in locked cabinets accessible only to staff with authority and access to the securely held key.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff stored medicines in a locked room, however medicines were not contained in locked cupboards to avoid unauthorised people accessing them. Whilst there was staff only access to the room, via name badges, all levels of staff could access the room including domestic and porter staff. This meant that those without the authority to do so, might access medication.

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. Medicines that required refrigeration were stored appropriately and fridge temperatures were checked.

Incidents

Staff recognised and reported incidents and near misses, however, some incidents were graded as no harm thereby potentially missing the opportunity for wider learning. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Managers investigated incidents using the Patient Safety Incident Response Framework (PSIRF) which was introduced as a new framework for managing incidents in November 2020. The framework outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

We requested a list of incidents reported from December 2020 to March 2021. Data provided indicated 264 incidents reported, 24 of those were graded as no harm for post-partum haemorrhage (PPH) with blood loss of over 1500mls up to 3000mls. These had been reported in line with local policy; Postpartum Haemorrhage, version 5 (Colchester only) that states major haemorrhage above 1500mls must be recorded as an adverse incident. However, by rating the PPH incidents as no harm, there could be missed opportunities to review incidents in greater detail and use this detail to improve practice. It could also impact on whether there was appropriate follow up of the women to ensure they recovered fully following discharge.

Staff knew what incidents to report and how to report them. We saw evidence of when incidents happened and what learning took place as a result. For example, a student checked the resuscitaire before the midwife used it; an error happened in between the check and the midwife using it which was picked up and staff used the incident as a learning opportunity and shared the learning with staff via the practice development sessions to avoid future occurrences.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff had access to an electronic incident reporting system and were trained to use it. Staff recorded incident discussions in minutes from meetings. We had discussions with staff about incidents, learning and improvement where they demonstrated an understanding of incidents and how to improve women's safety.

The practice development midwife shared incidents where learning was used to make changes to improve safety. The practice development midwife carried out regular skills and drills exercises which were unannounced and used to provide examples of learning and improvement. These exercises were multi-disciplinary which was in line with Saving Babies Lives guidance.

Staff understood Duty of Candour. They were open and transparent and gave women and families a full explanation when things went wrong. We saw this documented within women's records and in incident related documentation we reviewed. Staff were able to provide us with examples of when they would use duty of candour and described the underpinning principles.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff told us they did not always receive feedback despite following process and completing incident reporting following policy. However, we saw some evidence of feedback in documentation, including audits where errors had been observed and staff were emailed to raise awareness. We also saw examples of change as a result of incidents raised.

Maternity

Is the service effective?

Inspected but not rated

Evidence based care and treatment

Information about the outcomes of women's care and treatment were routinely collected and monitored. The trust had a maternity dashboard in place, based on Royal College of Obstetricians and Gynaecology guidance, which was included in the Patient Safety Incident Response Framework (PSIRF) as part of the maternity assurance report. PSIRF supports the NHS to further improve patient safety and outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

Prior to inspection we reviewed the maternity dashboard dated January 2020 to January 2021. The dashboard was RAG rated with targets set for smoking, intrapartum transfers of care, mode of delivery and neonatal morbidity and mortality. We saw some improvements, for example the target for women smoking at delivery was consistently met but were red (slightly above the 30% target) in relation to reducing C-sections.

The trust engaged in national programmes to improve delivery of maternity services. The trust provided us with information in response to The Clinical Negligence Scheme for Trusts (CNST). This was an incentive scheme that outlined ten essential actions designed to improve the delivery of best practice in maternity and neonatal services. There were five key areas in line with national guidance (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). We reviewed the trust reports for the regional perinatal quality oversight group (RPQOG) meetings in December 2020, February and April 2021. Latest compliance (as of April 2021 meeting, based on February data) recorded that trust was on track (green) for all 10 aspects CNST, and for all five aspects of Saving Babies Lives.

Leaders completed a maternity assessment assurance tool in response to recommendations from Ockenden report. This independent report outlined seven immediate and essential actions based on emerging findings and recommendations. The tool demonstrated the trust's compliance. Latest compliance (as of the RPQOG April 2021 meeting, based on February data) demonstrated the trust were on track to meet the requirements set out in the report with five complete actions and the remainder on track (green).

Staff participated in local and national clinical audit programmes to review effectiveness of care and treatment. We reviewed several audits where we saw identified staff, related actions and process for review to determine improvements. For example, staff audited reducing smoking in pregnancy, the audit planned to confirm whether 80% compliance threshold met and action plans to improve compliance. We saw audits for fresh eyes, audits of swab counts, WHO safety checklist audits with associated action plans and evidence of completion. This meant that staff engaged in initiatives to monitor and improve effectiveness.

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Maternity

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Staff were monitored using an effective system to prompt training, learning and development and ensure competencies. Staff were up to date with specialist training, and received regular updates, for example, cardiotocography (CTG) training; audits for compliance were carried out and skills and drills took place regularly to observe and learn from practical exercises.

Practice development midwives (PDMs) organised 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. The PDMs also facilitated skills and drills, learning from incidents and offering additional training when identified following audits. This meant there was a focus on competency and ensuring staff were effective in their roles to keep people safe.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff appraisals compliance rates were consistently met. Qualified and unqualified staff appraisal overall compliance was 93%. Consultants were 100% compliant and doctor appraisal compliance rates were 64%. Medical staff appraisals were suspended during Covid-19 which may account for the low compliance rate.

Staff were trained to deliver the Practical Obstetric Multi-Professional Training (PROMPT) approach to obstetric emergency training.

Prior to inspection we reviewed the patient safety incident response plan (PSIRP) and the maternity assurance report relating to dashboard outliers (February 2021). It was stated that, as a trust, there was poor obstetric compliance with attendance to in house PROMPT training, which covers teaching on PPH skills & drills and human factors. It had been identified and escalated to the clinical leads and all doctors working within the service were allocated sessions to attend. We found that this had been successful, and the team were over 90% compliant for attending the training in March 2021. PROMPT training is thought to improve knowledge and teamworking. It is also associated with significant improvements in outcomes for mothers and babies. The trust provided us with a breakdown of compliance of maternity staff who attended the training and it demonstrated that midwives were 97% compliant, support workers 98% compliant, doctors and consultants 100% complaint, however anaesthetists were below target having achieved just 59% compliance.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care. However, multidisciplinary meetings were inconsistent and not always formally structured. There were missed opportunities to work cohesively across the Trust.

Staff held regular multidisciplinary meetings to discuss women and improve their care, however they were not always well structured. We observed several meetings/huddles throughout the day with medical staff and multi-disciplinary teams. Some were well facilitated, involved all the key people with a clear format. Some were overcrowded, regularly interrupted and people did not always stay for the entire meeting. Staff who facilitated handovers did not a follow a structured format, for example, using a situation, background, assessment, recommendation (SBAR) format. SBAR is a tool used to facilitate prompt and appropriate communication between wards and services.

Staff did not have regular cross-site multi-disciplinary meetings or interactions with colleagues at Ipswich Hospital maternity unit around managing women's care. Staff from each site used different policies and guidance documents despite being the same trust and sometimes sharing the same women. This meant that staff had different ways of working that were not consistent and cohesive to help facilitate effective care for women across the two sites.

Maternity

Is the service well-led?

Requires Improvement

Leadership

There had been significant change in senior leadership, resulting in vacant positions, which had led to an instability in the team with a gap in accountability and ownership. Leaders were not making a demonstrable impact on the quality or sustainability of services.

The service had undergone significant change in management and leadership which led to an unstable structure. The maternity service sits within the Women's and Children's division. The service is led by a divisional management team, comprised of a divisional director, an associate director of operations and head of nursing, women's and children's; There was no director of midwifery, however the position had been recruited to and they were due to start in September 2021. There was also no clinical director to provide clear accountable leadership and oversight to ensure the smooth running of the service. There was a nominated non-executive director (NED) with responsibility for maternity to provide challenge and independent oversight. The head of midwifery worked alongside a number of managers including an obstetric governance lead, labour ward lead and matron.

Leaders at executive level and maternity leads did not demonstrate they always understood and managed the priorities and issues the service faced. They were not visible and approachable in the service for women and staff. They did not always support staff to develop their skills and take on more senior roles. We saw no evidence of succession planning. This meant there were gaps in leadership capacity and capability. We were not assured that clear priorities for ensuring sustainable, inclusive and effective leadership were in place. There was no leadership strategy or development programme.

The trust's leadership team were aware, and able to relay, the challenges to quality and sustainability. However, there had been a continued delay in implementing the necessary improvements needed to support the overall strategic direction of the service. This impacted on the service's quality of delivery and the wellbeing of staff.

The services senior leadership team, midwifery staff and medical staff reported a prolonged poor culture and fragmented relationships. Leaders in the service reported disconnect from the executive team and lack of clarity to help overall satisfaction. Whilst each location continued to work in silo, with different processes and policies, such as the post-partum haemorrhage policy, there was the potential for fragmented leadership and a lack of cohesive oversight of quality and risk.

The head of midwifery (HOM) met with the chief nurse, however, they did not have regular contact with the divisional director or have direct access to 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.' All maternity staff we spoke with reported a disconnect and lack of regular and effective interaction with the divisional leadership team.

Maternity

Staff told us that the governance structures were outdated and because of this staff were unclear of their roles and responsibilities and accountability. Those with dedicated specialist leadership roles were unclear about lines of responsibility and told us that they were not allocated enough additional hours to provide effective governance oversight.

Maternity safety champions were recently employed to promote a professional culture needed to deliver better care. They played a central role in ensuring that mothers and babies were kept safe in maternity services. We saw posters displayed to inform staff of the maternity safety champions and we were updated during provider engagement about the roll out of the maternity safety champions. However, despite this all staff we spoke with were unclear about the role of maternity safety champions and did not feel engaged with the safety champions or the process.

Vision and Strategy

There was no clear vision or strategy in place to deliver high quality sustainable care and no robust plans to deliver.

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action. The trust told us the maternity strategy and vision was still to be developed in partnership with staff and stakeholders, and that this would be a key objective for the service once the Director of Midwifery was in post. This meant staff did not have strategy and vision to provide clear goals and direction against which to measure their value as a group of staff who worked hard to provide good quality care.

As it was yet to be developed there was no alignment to local plans in the wider health and social care economy, and lack of evidence that services were planned to meet the needs of the population.

Whilst there was recognition by the executive team that this would be undertaken once the DOM was in post, we were concerned that there was a continued delay, with no clear direction or involvement of the midwifery and medical staff.

Culture

Staff did not always feel respected, supported and valued, detailing a lack of consistent support.

The service had gone through prolonged periods of change, a pandemic, significant changes in leadership, lack of strategy and lack of a robust governance framework which impacted on staff morale and wellbeing. The trust told us of initiatives they introduced to support service provision during Covid-19 and individual career development. For example, registered general nurses were supported with training and supervision to work alongside midwives and student midwives at the hospital could be fast tracked to complete their qualifications.

During the inspection staff were friendly, helpful and warm when we spoke with them and in our observations. Staff at all levels were clearly concerned about staffing, leadership and staff morale. Staff were visibly tired, some burnt out and some tearful. Staff did not feel listened to. Staffing shortages were escalated but there was a lack of consistent support.

The culture did not always encourage openness and honesty. At the time of inspection there were two external reviews focused on continuity of carer and ongoing culture and leadership**.** We were concerned that there had been significant delays in organising these independent reviews. During one of our regular engagement meetings in August 2020 we were informed the trust was committed to improving the culture hence the intention for an independent review. However, terms of reference were not formalised until December 2020 and the review only started in March 2021.

Maternity

Staff expressed their desire to provide an effective and safe service however they were concerned about the scope of practice based on staffing shortages and lack of structure and leadership. Staff were very busy when we inspected, however we saw that they worked well together for the safety and wellbeing of those in their care. Staff wellbeing initiatives were introduced. For example, exercise groups and challenges, encouragement to be outside, kindness nominations with donated prizes, for example, a two-day camping trip. These new initiatives were as a result of listening to staff and hearing their concerns.

Governance

Governance structures, processes and systems of accountability were unclear to staff. Levels of governance and management did not function effectively or interact with each other. Staff were not clear about their roles and accountabilities.

Leaders operated an ineffective and indistinct governance system and structure throughout the service. Staff were not always clear about their roles and accountabilities; this meant they were unclear about expectations of them and were disengaged from executing work to ensure smooth running of the service. Staff told us they did not have regular opportunities to meet, discuss and learn from the performance of the service. One member of staff told us the governance framework was outdated and had not been reviewed in over seven years. Staff told us they were concerned that lack of governance impacted in overall safety and wellbeing of already fatigued staff. We were told that governance meetings had been halted for over 18 months. However, we saw there were unit meetings, women's quality and risk meetings and regional perinatal quality oversight group (RPOCG) meetings in place. This meant there was some disconnect between staff and their understanding of the governance system.

Leaders did not have a robust response to tackle staffing shortages and concerns. Leaders had rolled out recruitment campaigns, however, did not use all means at their disposal, in a timely manner to cover staff shortages. For example, the trust did not use agency midwives to backfill vacancies or absences to support substantive staff in their roles in providing safe and good quality care. Leaders were aware of staffing concerns over an extended period which meant they could have acted sooner to ensure appropriate provision of safe staffing. Staffing shortages, and the use of supervisory staff in clinical duties resulting in their unavailability to support junior staff, was raised during the last inspection.

Medicines management systems were not robust. Storage facilities were not adequate to avoid unauthorised access. We saw no evidence of this being identified as a risk in either risk meeting minutes or the risk register.

Leaders did not provide a safe and efficient triage system for staff to safely and effectively manage women who used this service. The system had too many functions, staffing numbers were not sufficient to fulfil all the roles and responsibilities within the triage room. We found a high number of incidents reported by staff that impacted on safe service delivery, clinical care and overall satisfaction. Staff also told us that they did not feel their concerns were heard by leaders and we were not assured timely, appropriate action was taken to improve the triage system.

Staff did not consistently facilitate robust, well-structured handovers using recognised tools. This approach would have demonstrated information shared about women with colleagues was discussed, documented and used appropriately to keep people safe.

Management of risk, issues and performance

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

Maternity

There were systems and processes in place to identify risk. The maternity service had a 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 looked at the risk register and risks were in date and had been reviewed. However, there were some risks that had remained high for an extended period. Staffing remained an extreme risk in the risk register with bank staff recruitment extended rather than exploring other options, such as agency staff.

Handovers were not always well facilitated, and we could not be assured that staff received a full detailed handover where all aspects of women's care were shared and discussed to keep people safe.

Staff were provided with a services dashboard which was reviewed as part of the women's quality and risk meetings that took place monthly. The meeting minutes for these demonstrated good multi-disciplinary team attendance where the dashboard, audits, risk register and incidents were reviewed. Staff who attended used an action log to review completion and progress of allocated actions. We reviewed three months of data shared at the East of England regional perinatal quality oversight group (RPOQG) where incident management reflected an improving picture. For example, open incidents unactioned in December 2020 were 73 with 5 serious incidents, this reduced to 48 and 4 serious incidents in January 2021 and reduced to 27 with no serious incidents in February 2021.

In response to Ockenden, an independent report outlining seven immediate and essential actions based on emerging findings and recommendations in relation to maternity services, leaders completed a maternity assessment assurance tool. The tool highlighted the recommendations from Ockenden and related compliance. Managers had oversight through bi-monthly reporting to RPOQG and the trust were on track in relation to Ockenden, Clinical Negligence Schemes for Trusts (CNST) – NHS Resolution and the Saving Babies Lives care bundle. However, we were not fully assured that leaders had sufficient oversight of the metric requirements. For example, it was reported the all aspects of the CNST were green and on track, however on inspection we found insufficient staffing remained a concern and anaesthetists' compliance with PROMPT training was 59%. In relation to Saving Babies Lives v2 GAP training compliance was 77%.

Prior to inspection we reviewed the patient safety incident response plan (PSIRP) dated February 2021. The trust remained an outlier for post-partum haemorrhage (PPH) identified by the National Maternity and Perinatal Audits since 2017. PPH is associated with maternal mortality and morbidity and is therefore a high-risk emergency for women. Staff graded a high number of PPH incidents as no harm, this meant that there was potential for less robust review and identification of learnings.

We reviewed triage related red flags, for example delays relating to staffing and red aspects on the maternity dashboards (where targets had not been met and/or where we saw no improvement). We could see the trust were monitoring these areas of concern but there appeared to be a lack of pace to take significant steps to ensure improvements.

Both Colchester and Ipswich sites were undertaking quality improvement projects however these were paused during the pandemic, and it was documented that these would be reinstated when staffing and acuity were safe to do so. We remain concerned that with staffing consistently compromised performance and quality improvement plans remain paused.

Areas for improvement

MUSTS

Maternity

- The service must ensure that medical staff complete mandatory and safeguarding training and ensure compliance with the trust target. Regulation 12 (1) (2)(a)(c)
- The service must implement an effective governance system and ensure systems to manage risk and quality performance are effective. Regulation 17 (1)(2)(a)
- The service must ensure robust review of incidents to ensure they are appropriately graded and managed to keep women and babies safe and ensure appropriate follow up care is provided. Regulation 17 (1)(2)(a)(b)
- The service must ensure a robust strategy and vision to set out clear objectives and direction for the service and staff. Regulation 17 (1)
- The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)

SHOULDS

- The service should ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process.
- The service should ensure cross site working and consistency to improve relationships and share good governance including policies and procedures.
- The service should ensure they are infection prevention control compliant.
- The service should ensure multidisciplinary team working is improved.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and three specialist advisors, including two obstetricians and a midwife. The inspection team was overseen by Philippa Styles, Head of Hospital Inspec

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing