Cambridge University Hospitals NHS Foundation Trust

Addenbrooke's and the Rosie Hospitals

Inspection report

Addenbrookes Hospital
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Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services well-led?	**Outstanding**

Our findings

Overall summary of services at Addenbrooke's and the Rosie Hospitals

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Addenbrooke's and the Rosie Hospitals.

This location was last inspected under the maternity and gynaecology framework in 2017. Following a consultation process CQC split the assessment of maternity and gynaecology in 2018. As such the historical Maternity and Gynaecology rating is not comparable to the current maternity inspection and is therefore retired. This means that the resulting rating for Safe and Well-led from this inspection will be the first rating of maternity services for the location. This does not affect the overall Trust level rating.

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

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

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

The Rosie Hospital is a purpose-built women's and maternity hospital which is located adjacent to Addenbrooke's Hospital in Cambridge. The Rosie hospital is a tertiary unit with a level 3 neonatal intensive care unit which accepts infants from 22+0 weeks gestation. The hospital serves the local population of Cambridgeshire, extending to parts of North Essex, East Hertfordshire, Suffolk and Bedfordshire, and specialist services in high-risk obstetrics and fetal and maternal medicine are provided to the whole of the Eastern region.

Maternity services include an early pregnancy unit, maternal and fetal medicine outpatient department, maternity assessment unit, antenatal ward (Sara ward), delivery suite, midwifery led birthing centre, two maternity theatres, postnatal ward (Lady Mary ward), an obstetric close observation area (OCOA), ultrasound department and an obstetric physiotherapy department. From April 2021 to March 2022 the total number of births was 5,573.

Our rating of this hospital stayed the same. We rated it as Good because:

- Our ratings of requires improvement for the maternity service did not change the ratings for the hospital overall. We rated safe as requires improvement and well-led as good and the hospital as good. Our reports are here:

Addenbrooke's and the Rosie Hospitals - https://www.cqc.org.uk/location/RGT01

How we carried out the inspection

This maternity thematic review was a focused inspection; we inspected the domains of safe and well-led using the CQC's specific key lines of enquiry designed to support the National Maternity Services Inspection Programme.

Our findings

Inspectors visited maternity services on 11 May 2023. We spoke with 35 staff and reviewed six sets of maternity care records and prescription charts. We asked women and birthing people to share their experiences with us and we received 52 responses.

We requested and reviewed documentary evidence to support our judgements including training records, audits results, standard operating procedures, staff rosters, meeting minutes, recently reported incidents and quality improvement initiatives.

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

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated this service as requires improvement because:

- Not all staff had completed an updated safeguarding children and adults training in line with the trust policies.
- The service did not always have enough medical staff which put women, birthing people and their babies at risk of unsafe care.
- Staff felt respected but did not always feel supported and valued.
- People could access the service when they needed it however, lack of adequate staffing levels meant they sometimes had to wait to be reviewed by medical staff.

However:

- Staff had training in key skills and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service was focused on the needs of women receiving care, managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services. All staff were committed to improving services continually.

Is the service safe?

Requires Improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated safe as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however, compliance rate did not always meet the trust target in maternity services.

Staff received but were not always up to date with their mandatory training. The maternity services training was comprehensive and met the needs of women and birthing people. Training was divided into trust mandatory training (core skills), and essential for role which included maternity specific modules and multi-professional obstetric simulated emergency training. Training included a mixture of online courses and face to face multi-professional simulated training. However, staff were not always completing training in line with trust policies. The overall compliance training rate at the time of this inspection for midwives was 84% and for medical staff 83%. This was below the trust compliance target of 90%.

Maternity

Midwifery staff compliance for training met trust target including equality, diversity and human rights 99%, conflict resolution 99% and fire evacuation 97%. However, compliance with some training was below trust target including professional obstetric multi-professional training (PROMPT) 75%, Basic Life Support 72%, annual cardiotocograph (CTG) 86%, breastfeeding 63%. Newborn Basic Life Support (NBLS) 86% and moving and handling level 2 (including pool evacuation) 78%.

Medical staff compliance for training met trust target including basic prevent awareness, 98%, equality, diversity, and human rights 94%, PROMPT 93% and for duty of candour 94%. However, medical staff did not complete training that met trust target for basic life support 70%, CTG 86% and infection prevention and control 85%.

The service completed a training needs analysis for the year 2022/2023 for all midwifery and medical staff. This outlined the mandatory and maternity specific training requirements and a local 3-year training plan. This was in line with national recommendations made in the 2020 Ockenden report and 2021 NHS Resolution Maternity Incentive Scheme.

Managers monitored mandatory training and alerted staff when it required updating. Practice development midwives were responsible for monitoring compliance with mandatory training and followed up with staff who did not attend training. However, they informed us that due to recent staff strike actions and staffing levels, compliance had been lacking. The service had an action plan in place to ensure training was kept up to date by summer 2023. The trust recognised the impact of lack of training and had included this on their corporate risk register. The risk oversight committee discussed risks monthly to provide assurance that appropriate risk management was in place, with challenge of control gaps where required.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, staff safeguarding training was not always up to date in line with trust compliance targets.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that adult safeguarding training (Level 1 and 2) for medical staff was 89% and for midwifery staff 94%. However, adult safeguarding level 3 training was 17%, and 34% respectively, which fell short of trusts 90% target. Training records also showed that children safeguarding training (Level 1 and 2) for medical staff was 91% and for midwifery staff 93.2%. However, children's safeguarding level 3 training for medical staff and midwifery staff was 57% and 81% respectively, which fell short of trusts 90% target.

The trust informed us that safeguarding adults' level 3 training was introduced on to the trust digital platform in February 2023. The data and audience required to complete the training was not fully embedded and therefore, the figures may not accurately reflect the completion rate.

Despite the lack of training, staff demonstrated their understanding of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). They gave examples which showed their knowledge and understanding of safeguarding women and birthing people including those with protected characteristics.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified, a colour coded flag was used to identify and highlight a safeguarding concern on the trust electronic system to ensure staff were aware and the support to provide.

Staff knew how to make a safeguarding referral and who to report to if they had concerns. Staff told us they felt confident to inform the safeguarding leads if they had any concerns. The service had specialist safeguarding midwives with designated roles in areas including female genital mutilation (FGM), mental health, young mothers, domestic abuse and substance misuse. The safeguarding lead was visible in clinical areas and carried out daily safeguarding reviews of women and birthing people at risk. They were involved in the birth plan and supported staff to safely discharge women and birthing people back into the community.

Staff followed the baby abduction policy and undertook baby abduction drills. The baby abduction alarm was rung during the safety huddle to ensure new starters were aware of the sound. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors had secure access. The service had practised what would happen if a baby was abducted, a baby abduction drill was last carried out in April 2023.

The safeguarding lead and midwives attended safeguarding strategy meetings with other agencies including the local authority to plan and support women and birthing people, when required. The team demonstrated a commitment to protect and maintain the security and well-being of women, birthing people, and their families,

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. However, staff did not always use "I am clean stickers".

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. The maternity services had systems in place to keep areas clean and free from infection and monitored their effectiveness. There were systems to ensure the deep cleaning and decontamination of rooms following a discharge or transfer.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service generally performed well in their infection prevention and control audits. From February to April 2023, the service achieved an overall 98% compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE) where required. Leaders and managers completed regular infection prevention and control and hand hygiene audits. A score of 94% was achieved for hand hygiene in January 2023. Where issues were identified during audits, appropriate action plans were in place to improve the cleanliness of the service. These issues were also discussed at divisional infection control meetings to ensure improvements were made.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients, and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas. Staff disposed of clinical waste safely. Staff labelled sharps bins correctly and made sure they were not over-filled. Staff separated clinical waste and used the correct bins. Staff checked formula and breast milk fridges daily to ensure the milk was safe for use.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use to ensure equipment was clean and ready for use. We saw that birth pools had a “pool is clean” label. We also saw I am clean sticker on some equipment including breast pumps. However, “I am clean stickers” were not consistently used to demonstrate areas and equipment that had been cleaned and when they were last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, the maternity unit was not always well sign-posted and the service had limited theatres.

The design of the environment followed national guidance. The maternity unit and the birth centre were clean and spacious. The maternity service had various departments; however, we were concerned some wards or areas were not always well sign posted. For example, antenatal ward and postnatal wards were called Sarah ward and Lady Mary ward respectively. The service informed us the trust had a ‘Wayfinding App’ and directions online for women and birthing people to use.

Leaders told us the service submitted a business plan to change the layout of some units including triage. The service had two theatres however, one was small and not spacious. The service had an increasing amount of elective caesarean section rate and needed a third theatre space to enable them keep up with demand and maintain safety standards. Leaders informed us the hospital had plans to refurbish the second theatre to meet required standards.

In triage, midwives assessed women and birthing people experiencing concerns during pregnancy or newly postnatal. However, between the hours of midnight to 8am, triage was carried out by members of staff on the delivery suite as there was no designated receptionist in triage overnight. A midwife often manned the desk and signposted people including allowing them access to the unit. The service had a business case to ensure triage is adequately staffed 24 hours a day, to avoid being diverted to the delivery suite which can cause delay in response at busy times.

It was the trust policy to carry out ligature risk assessments in high-risk areas where mental health patients would normally be placed. As part of maternity service antenatal care pathway, a mental health risk assessment was completed for each woman and birthing person. Leaders informed us if they had any concerns for example where a person expressed suicidal ideas, this would be escalated to site safety team to ensure appropriate support was in place including one to one care.

Staff carried out daily safety checks of emergency specialist equipment most of the time. For example, for a neonatal resuscitation trolley, there were 17 missed checks from Jan 2022 to April 2023. However, the service had a system to escalate any missed equipment checks. An online system called ‘Mykitcheck’ had been implemented to monitor and improve equipment checks including emergency trollies across the service. Where checks were not carried out as planned, this was escalated to appropriate line managers.

Equipment had a personalised identification code and staff used an electronic device to check equipment. This showed when equipment was last checked and what type of check was required. A daily check included cleanliness, functioning, tamper tags and gas levels, and a weekly ‘full check’ also included checking of consumable expiration dates. All equipment we reviewed on the day of our inspection had been serviced within the last year and had portable electrical appliance safety testing stickers displayed to confirm this.

Maternity

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There was a recliner chair next to each bed to accommodate birth partners where they wish to stay. However, the maternity and neonatal voices partnership (MNVPs) told us more could be done for example by providing birth partners with separate shower and toilet facilities.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. Staff had access to adult and neonatal emergency resuscitation equipment. Staff had access to portable computers so they could complete their documentation by patient bedside.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration; however, staff did not always monitor waiting times for women and pregnant people for when they were reviewed by a doctor.

We reviewed six maternity care records. Appropriate risk factors were identified including ethnicity, those living in a deprived area, having a high body mass index, comorbidities or aged 40 or over. Women were allocated to the correct pathway to ensure the correct team were involved in planning their care. Their risk assessments were completed at every contact and where required and there was evidence of appropriate referrals.

Women had a holistic risk assessment when they booked for care. They received two appointments; the first one was to take bloods and complete physical observations and the second one was to take a full history of their social, medical, and emotional needs. However, the service did not pre-arrange face to face interpreters for non-English speaking women. They relied on language line once the woman arrived for care. Staff told us this caused delays in reviews whilst waiting for the interpreter and the lack of body language meant information could be lost in translation.

Staff accessed blood and screening results via the patient record. Staff completed carbon monoxide (C0) monitoring as part of the Saving Babies Lives version 2 care bundle. The service achieved a 94% compliance at the booking visits in March 2023 against a target of 95%. However, the service compliance levels for CO monitoring at 36 weeks was low at 77% in March 2023. Appropriate actions were in place to educate and refresh all clinical staff knowledge and skills to ensure this assessment was embedded in practice.

Staff offered women and pregnant people vitamin D supplementation and ensured they understood the importance of vitamin D. Women were screened for mental health and safeguarding concerns including domestic abuse or child sexual exploitation. Staff used this information to plan care and involve the right level of support and partner agencies.

Staff knew about and dealt with any specific risk issues. Patient record showed alerts for various aspects of risks which included diabetes, reduced fetal movement and growth, safeguarding and smoking. Staff reviewed care records from antenatal services for any individual risks. Data on the maternity dashboard showed in March 2023, staff completed venous thromboembolism (VTE) assessment for 51% of women and birthing people when admitted to hospital and 86% of women had the postnatal VTE assessment completed within four hours of birth. Prior to that no data was submitted on their maternity dashboard. Following our inspection, the service informed us they experienced challenges with VTE records and were in the process of rectifying them. They sent us evidence to show a 98% compliance with VTE assessment at booking.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff also used the Newborn Early Warning Trigger and Track (NEWTT) national tools to assess and identify deterioration in new-born babies. We reviewed six MEOWS records and six NEWTT records and found staff correctly completed them and had escalated concerns to senior staff when required. A MEOWS audit carried out from September 2019 to February 2023 showed an overall maternity compliance of 72.5% for admission observations within 30 minutes of arrival against a trust target of 100%. A NEWTT audit carried out in January 2023 showed 100% of babies had all observations documented within their records and over 85% had the appropriate red, amber, green (RAG) rating documented in the flowsheet.

Staff completed risk assessments for each woman on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff in triage used a risk prioritisation tool when assessing women and pregnant people. Managers introduced the traffic light red, amber, green (RAG) rated system in May 2021. The system was designed to make sure that those women most in need were prioritised and seen within safe timeframes. Leaders monitored wait times to be reviewed by midwives. However, the service did not have a dedicated registrar assigned to this area and did not monitor wait times to see how long women and pregnant people waited before being seen by a doctor. A maternity triage audit carried out in April 2023 for 20 women and birthing people showed only 55% of women were seen by a midwife for initial triage within the specified timeframe covered. The audit did not include how long women waited to be reviewed by a medical staff. This meant that during peak times women had to wait longer than national guidance suggests.

The service did not have a designated triage line but provided one contact telephone number for all women and pregnant people to call about any aspect of their pregnancy or childbirth. All calls were recorded on the electronic patient record, so staff had oversight of how frequent women and pregnant people called. The triage telephone line was monitored by a band 6 midwife who could work remotely; they took calls and signposted women to the correct department or made appointments for them. Managers told us that if a caller waited too long to be answered, the calls were diverted to the labour ward for a midwife to answer.

Staff followed national and local guidance to monitor fetal wellbeing before and during labour. Staff used a systematic hourly fetal wellbeing review tool within the electronic patient record, including a ‘fresh eyes’ element, to carry out fetal monitoring safely and effectively. The service had recently recruited a fetal wellbeing midwife to oversee training and support staff competencies. Their role included providing service leaders with audit data to ensure staff compliance to completing fetal wellbeing assessments when using handheld dopplers (a device used to monitor the fetal heart) and Cardiotocography (CTG) machines and the interpretation of the outcomes.

Managers monitored compliance with the use of intermittent auscultation during labour (monitoring fetal heart with a handheld device) and CTG processes. Records from October 2022 to December 2022 showed that staff compliance with all aspects of monitoring fetal wellbeing fell short of the 100% target. For example, in December 2022 only 4 in 10 patient records assessed (40%) showed evidence of a documented initial risk assessment at the onset of childbirth for the appropriate mode of fetal monitoring in the delivery unit. In the delivery unit,only 30% of patients reviewed had a documented maternal pulse when staff applied the CTG machine. Furthermore, in December 2022, only 6 in 10 records showed that in the delivery unit, concerns in relation to fetal monitoring were escalated to a doctor when required. The findings were presented to the Maternity Safety Improvement Group in February 2023 and the following actions were agreed:

1. The new fetal monitoring lead would ensure fetal wellbeing training was moved to face-to-face sessions to improve competency assessments, and one-to-one training where needs were identified.

2. The service to ensure the availability of sonic aids prior to commencing CTG as more had been ordered for intrapartum areas and equipment check processes reviewed in delivery unit.
3. Continued audit to be recommenced once the fetal surveillance midwife was recruited.
4. Continued schedule of CTG and K2 training (A risk management tool which summarises the important information for all women and birthing people on the delivery suits including both high risk and low risk) in place.

The service was working to improve the 3rd and 4th degree perineal trauma rate. Data showed that the rate varies from month to month. For example, in November and December 2022 the rate was within the ≤3.5% limit expected by the trust, National Maternity Perinatal Audit (NMPA), and also the local maternity and neonatal network system (LMNS). However, the rate increased in January and February 2023 to over 5% which breached the limit. A multidisciplinary training session was carried out in March 2023 for 28 members of staff, and we noted that the service achieved an improved rate of 3% in March 2023.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The service maintained a secure electronic care record system which included a virtual white board of admissions used by all staff involved in women and birthing people's care.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. Staff used the situation background assessment and recommendation (SBAR) algorithm to help share information and handover care throughout the service. Staff kept their electronic records up to date with relevant information. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles during each shift to ensure all staff were kept up to date with key information. An electronic handover board was used during handovers and each member of staff also had an up-to-date handover sheet with key information about women and birthing people. Handovers were completed in a room and was kept confidential. Staff attended once a week 'take 5' messages and feedback sessions to discuss themes and incidents that had occurred to enable them learn lessons and to improve on practice.

Theatre staff completed a World Health Organisation (WHO) Surgical Safety Checklist, when women and birthing people arrived in theatres. Staff recorded swab counts and ensured they were complete before the woman left theatre. From February to April 2023, staff achieved 100% compliance in the World Health Organisation (WHO) surgical safety checklist audit.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff risk assessed babies at birth and referred at risk babies to the neonatal team for additional care and treatment. The service provided transitional care for babies on the post-natal ward in order to keep mothers and babies together. A paediatric transitional care ward was available for babies who required longer inpatient stays (and mothers were also able to stay 24/7 with their babies on this ward). The service had a neonatal specialist nurse who supported risk and quality reviews and to ensure the service complied with Avoiding Term Admissions into Neonatal Units (ATAIN).The service had an action plan to reduce the number of term admissions into the neonatal unit. After our inspection visit, the service informed us they had progressed with their action plan and had achieved an 'avoidable term' admission rate of less than 0.2%.

A Sepsis Risk Calculator (also known as the Kaiser Neonatal Sepsis Calculator and the Early Onset Sepsis Calculator) was used. A RAG rating pathway was observed for all babies. Babies who were at potential risk were reviewed within 1hour by a paediatrician followed by regular observations.

The service had dedicated bereavement midwives who support women, birthing people and their families during this period. Families had access to an around the clock chaplaincy service. The hospital provided a memorial garden where families could go to spend time.

The service had two ensuite and furnished bereavement rooms located in a private area to care for bereaved mothers, birthing people, and their families up to their discharge. The suite also had cold cots for babies so that parents were able to spend time with them to say goodbye. There were memory making pots which included memorial cards and staff had access to various clothing designed for very small babies who had passed away. Staff understood and accommodated the different cultural customs associated with death and bereavement. For example, early burials could be arranged for babies from Muslim families, if a post-mortem was not required.

Midwifery Staffing

The service had 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, appropriate staff skill mix was not always in place.

The service had improved their midwifery staffing levels to keep women and babies safe. Data provided by the trust showed that there was sufficient staffing in place in most departments in the maternity service. The total vacancy rate in March 2023 was 1.74% which equates to 3.80 full time equivalent posts in total across band 5 and 6.

The national average of midwife to birth ratio is 1:25 (dependent on unit acuity). Since November 2022, the maternity service was at a funded establishment of 1:24 which included a total of permanent and bank clinical midwife and this was within trust targets.

Since November 2021, the service had undertaken an international midwife recruitment programme to improve staffing levels. Therefore 30% of the midwifery workforce were junior band 5 staff undertaking their preceptorship programme. Staff informed us that staffing varied but had improved.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings’. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Leaders produced a quarterly red flag report. From January to March 2023, the service reported 212 red flag events for missed or delayed care and 241 events for delay of 30 minutes or more between presentation and triage. The service had a safer staffing red flag procedure which was last updated in September 2020

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support staff needed for each shift in accordance with national guidance. However, appropriate numbers of staff with the right skill mix was not always available. Data from Birth rate plus workforce review reported in August 2022 showed that the current total clinical funded bands 3 to 7 was at 220.73 whole-time equivalent (WTE) against a Birthrate plus recommended establishment of 231.06WTE. a shortfall of 10.33WTE.

The service had two supernumerary shift coordinators or bleep holders who had oversight of the staffing, acuity, and capacity on each shift. The bleep holder visited each ward daily to assess whether the clinical needs of women and birthing people on the ward matched staffing levels. The bleep holders assessed staffing levels of the maternity service

at least four times each day by liaising with the midwife-in-charge of each ward and then escalated any concerns at site safety meetings. The site safety meeting took place five times in every 24hour period to review all matters relating to the safety of the maternity service. Where required, staff were redeployed to areas where needed to maintain patient safety, patient flow, and support staff workload.

Matrons were responsible for planning staffing levels, assessing acuity and activity within their areas. They liaised with the bleep holder to resolve any issues relating to patient flow in their clinical areas. Managers and Leaders reviewed staffing weekly in their clinical areas to ensure appropriate staffing had been forward planned for, to maintain both patient and staff safety.

The service had an up-to-date escalation and closure of the maternity service policy. This policy enabled flow and maintained safe standards of care for women, birthing people and their babies during periods of very high activity, acuity and significantly low staffing levels. Records showed that the unit had closed 40 times from April 2022 to March 2023. The closures resulted in 36 women or pregnant people being referred and 18 women or pregnant people giving birth in another unit. Over the 12-month period, lack of staffing was the most common cause for the diverts.

Managers ensured women received one-to-one care in labour. Data showed that out of 2686 women and birthing people attended to on the delivery suite from October 2022 to March 2023, there was two red flags identified for when one midwife was not able to provide continuous one-to-one care and support to a woman during established labour.

The service had reducing vacancy rates and turnover rates for midwifery staff. Since October 2022 to March 2023, the service had a sickness rate between 4% to 4.5% for midwifery staff. This was against a trust target of 3.5%. From October 2022 to March 2023 the overall maternity absence rate for midwives was 8%. Staff told us that maternity leave, sickness, annual leave rates added further pressure on the service.

Managers encouraged the use of bank staff already familiar with the service to enable a reduction in the reliance on agency staff who were less familiar with the service. Managers ensured bank staff had a full induction, completed all mandatory training, and understood the service.

There was a system in place to support and develop staff through yearly, constructive appraisals of their work; however, not all staff were supported with annual appraisals in line with trust policy. The education team and the professional midwifery advocate (PMA) supported midwives. The last updated appraisals record on 16 January 2023, showed 59% of staff with their annual appraisal for the 2022/2023 appraisal year. We heard mixed views from staff about annual appraisals. One member of staff told us they had received yearly appraisals whilst another member said they had not received an appraisal in four years. The management team acknowledged the need to improve appraisal rates.

Managers ensured staff were competent for their roles. The maternity service had a preceptorship programme to ensure Band 5 midwives were trained and given exposure to all aspects of midwifery care. The education team and the professional midwifery advocate supported staff and assessed their competency so they could achieve a band 6 status.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep women and babies safe. Women attending triage often did not have timely medical reviews because medical staff also provided cover for other units including the delivery suite

maternity assessment unit. Staffing arrangement for triage included obstetric staffing by a dedicated senior house officer from 9am to 7pm Monday to Friday with delivery unit registrar cover and consultant cover from maternity assessment unit and delivery suite. There was no dedicated registrar cover for triage and staff told us that this led to delays in reviews particularly in the afternoons. Also, leaders did not have full oversight of how long people were waiting and how often waiting times exceeded expected timeframes and national guidance.

Lack of medical staffing impacted on the support maternity triage received to maintain safe care for women and birthing people. The service aimed at implementing standardised risk prioritisation assessment tool for maternity triage. However, as the service did not have a registrar dedicated specifically to triage, they had not been able to implement this effectively. There were limited consultants often covering other areas including delivery suite and the maternity assessment unit and this delayed reviews due to acuity in other areas impacting flow and capacity through triage.

There were gaps in medical staff rota. Leaders confirmed there had been 4 gaps on the formal senior registrar rotas for some time and 2 gaps on the junior obstetric rosters which had also impacted on the senior house officers. The service had an increasing demand for caesarean sections which form 38% of their delivery and approximately 19% out of area women and birthing people choosing to birth at the service due to factors including reputation. Anecdotally the Trust are told by women and birthing people that other trusts refuse to support the choice of caesarean section. Although there had been a willingness from medical staff to cover and manage local risk levels for women and birthing people, this could not be sustained over a long period of time. In addition, the service confirmed 30% of midwifery workforce were junior staff and junior medical staff told us this impacted on their workload as they were expected to do more on their shifts. Junior medical staff said that they did not feel supported in their role. They had raised concerns relating to workload, training, and stress. Leaders told us they would be meeting with doctors to have one to one conversation and to discuss the support they could provide including their postgraduate medical training. They said rota for junior medical staff would also be reviewed to support them. Leaders acknowledged there were gaps in the rota and had tried to cover them by introducing 1 or 2 locums at a core level over the last few months. After our inspection visit, they informed us of plans to have 2 locums in a senior level for May and June 2023.

The service did not always have a good skill mix and availability of junior medical staff on each shift. There was often not a senior trainee to assist with complex cases and caesarean sections. Leaders had recognised the need to create an additional separate obstetrics and gynaecology on call rota at registrar level (ST4/5) in addition to the consultant rota to make sure there was adequate cover in both obstetrics and gynaecology areas to improve on patient reviews and flow across the unit. However, this had not yet improved medical staffing levels for maternity.

The medical staff did not match the planned numbers. Records showed that that there were three registrar vacancies within the service and leaders had found it difficult to recruit suitably experienced medical staff to cover the needs of the service. Leaders told us that to improve medical staffing, the service reached out to overseas doctors to fill these vacancies; however, the process was hindered by recruitment checks and language barriers. Also, Cambridge is a high cost of living area, with expensive parking restrictions but without the London higher cost of living allowance which meant this was mostly not an attractive working location.

The service had low and/or reducing turnover rates for medical staff. The sickness absence rate for medical staff within the obstetrics and gynaecology from October 2022 to March 2023 was 4.4% for November 2022 and March 2023. February sickness absence was also 4%. However, for October and December 2022 and January 2023 sickness absence was 2% or below which was better than 3.5% trust target.

The service had high rates of bank and locum staff. Managers used locums when they needed additional medical staff. For example, in March 2023 the service used 131 hours of agency and 268 hours of bank trainee grade doctors. The service also used 47.5 hours of agency and 45 hours of bank obstetric consultants. Leaders told us locum staff were regular staff that knew the service.

The service had a trust wide policy and procedure in place to appoint and induct locum doctors; this policy was last updated in January 2015. Managers informed us they completed an induction for locum staff, but we did not receive any evidence to support this. Also, the maternity service did not have a standard operating procedure to ensure that appropriate levels of induction was completed for all locum staff before they began work. Therefore, we could not assure ourselves that bank and locum medical staff received an appropriate level induction before they began working at the service.

Leaders informed us they were reviewing the obstetric consultant numbers in line with recommendations from the Royal College of Obstetrics & Gynaecology requirements for safe staffing. They said a business case was in development to address the increasing elective caesarean rates and increasing acuity on the delivery suite and this will encompass both obstetric and anaesthetic workforce to meet anticipated demands. The business plan would be submitted to the trust medical and dental workforce committee in July 2023.

There was daytime Consultant on site 'hot week' cover from 8:30 to 18:00 hours. An on-call consultant is on-site from 17:30 to 22:00 hours during the week, and on-call remotely from 22:00 hours, unless indicated to remain on-site. At weekends the on-site on-call service is from Friday to Monday from 08:30 hours to 22:00 hours. The remaining time has a consultant on call remotely, who is available to come on site as necessary. All consultant contracts with 10 programmed activities have a non-clinical day during the week. When a consultant on call night shift has high activity, the following day-time consultant duty is either stepped down or covered by a member of the consultant team if needed. This puts additional pressure on the obstetric consultant team. Junior medical staff would start on Monday and would do normal duties, then a twilight shift and then an on-call.

Consultant led ward rounds; these were used to review and plan women's care and for sharing learning with the rest of the team.

Leaders recorded a lack of medical staffing as a risk and produced bi-annual reports which were presented to the trusts board to ensure they had oversight of the current workforce capacity and to provide assurance of compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) standards.

Managers supported staff to develop through yearly, constructive appraisals of their work. By January 2023, 93% of medical staff had received an appraisal for the year 2022/2023 appraisal year. The outstanding 7% was due to maternity leave and staff not requiring an appraisal. This meant that medical staff had a clear understanding of their role and responsibilities.

Records

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

Maternity

Women's notes were comprehensive, and all staff could access them easily. The trust used electronic patient care records for most aspects of the care delivered. We reviewed six records for women at different stages of their maternity pathway and found records were comprehensive and up to date and included key risk and clinical assessment.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. The service used electronic records and electronic whiteboards for admission. Women had access to their appointments information, blood results and all communications via the trusts' MyChart app. In the event of a planned or unplanned downtime of the electronic patient record system, there was a process for business continuity access which included offline electronic notes access, printed notes access and reversion to paper documentation which was available in each clinical area. Paper records such as CTGs and consent forms were scanned onto the patient records to ensure their information was complete.

Results of a records keeping audit carried in March 2023 showed 64.9% compliance to their record keeping standards. The standards that were not met had been grouped into themes and appropriate action plans were in place to address these and managers continued to monitor staff compliance to documentation.

Records were stored securely. Computers were password protected and staff locked their devices when not in use. Staff also had access to portable and handheld devices which they used to record care by patient bedside.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Most staff completed annual medicines management training. Data showed 87% of midwives had completed medicines management training**.**

There were no routine medicines rounds as midwives administered medicines to the women and birthing people they were working with. Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. Staff carried out assessment for the self-administration of medicines with women and birthing people's consent and educated them to take their own medicines, where possible. However, during busy periods there was a potential for medication administration to be delayed because midwives were multi-tasking.

Staff completed medicines records accurately and kept them up to date. The service had an electronic prescribing system which staff use to prescribe and administer medicines. Midwives could access the full list of midwives' exemption medicines, so they were clear about administering within their remit.

The maternity unit had pharmacist presence to provide support and review medicines stock lists. We observed a medicines and controlled drug check being carried out by the pharmacist and there were no concerns.

Staff stored and managed all medicines and prescribing documents safely. Clinical rooms where medicines were stored were locked and could only be accessed by authorised staff. For example, the shift co-ordinator held the keys for the controlled drug cupboard. Staff carried out daily medicine checks including controlled drugs which were checked by two midwives to ensure there were no discrepancies, in line with best practice guidelines. Medicines were in date and stored at the correct temperature. Staff monitored and recorded fridge and freezer temperatures and knew to act if there was any variation. Staff told us they contacted the pharmacist team if they had any concerns.

The service had a robust system for checking and sealing emergency grab boxes. For example, the pre-eclampsia and post-partum haemorrhage grab boxes, which contain vital equipment and flow charts. Staff stored the medication aspects of each grab box in clearly labelled containers in the fridge.

Staff followed national practice to check women had the correct medicines when they were admitted, or when they moved between services. The service had effective system in place for the provision of take-home medicines during discharge and including out of hours.

Staff learned from safety alerts and incidents to improve practice. Monthly maternity safety meetings included any learning from medicines related incidents.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. 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.

Staff knew what incidents to report and how to report them. There was a clear reporting and recording process which staff understood and followed. Staff understood the various types of incidents that could occur throughout maternity and knew of their responsibility to report and record.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff had access and knew how to use the trust electronic reporting system to record concerns. Records showed that incidents were reported and recorded appropriately.

The service had no ‘never events’ on any wards in the last 12 months. Managers shared learning with their staff about never events that happened elsewhere. 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 had the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

Staff reported serious incidents in line with trust policy. Managers carried out weekly rapid review meetings to look at moderate and more serious harm or cases of concern that required further review. A serious incident executive review panel met weekly to discuss serious incidents, the level of investigation required and to identify and report any serious incidents that met the criteria to the Healthcare Safety Investigation Branch (HSIB) in line with national requirement and the National Perinatal Mortality Review Tool (PMRT) designed to provide parents with high quality investigations and highlight lessons learnt. From April 2022 to March 2023, the service reported four serious incidents of which three met the criteria for referral to HSIB. Two of these incidents related to intrapartum stillbirth.

Managers reviewed and completed investigations on serious incidents that did not meet HSIB criteria. The service also used external reviewers if there was the need for specialist approach to reviewing any serious incidents and were supported by patient safety team. The service monitors adherence to identified actions which were recorded on a RAG rated action plan and had a senior management oversight in the division.

The governance and risk team made sure 72-hour reviews of moderate and more serious incidents were completed with the staff involved in any incidents to begin an investigation and to identify any actions. Where immediate actions were identified, these were cascaded through all staff communication channels including team huddles.

Maternity

Managers investigated incidents thoroughly. Women, birthing people, and their families were involved in these investigations. Managers reviewed incidents potentially related to health inequalities and recorded ethnicity.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Managers monitored the service compliance to the duty of candour. Women were involved in investigations and had a point of contact, so they had continuity and support throughout the process.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers met to discuss the feedback and look at improvements to the care women and birthing people received. Staff received feedback and improvement plans through safety handovers, 'Take 5' themes and incidents, message of the week, safety huddles, emails, newsletters, private social media page for staff and learning from risk meetings. Staff met monthly to share any lessons learnt and best practice guidance.

There was evidence that changes had been made because of feedback. Staff told us that their clinical opinions were listened to at executive level. Another member of staff told us they felt empowered to speak up during governance and risk meeting. Where incidents occurred, actions were taken to improve patient experience. For example, staff were sent messages to inform them that silent labourers still needed care regardless of the patient's high pain threshold.

Managers debriefed and supported staff after any serious incident. Staff gave examples of additional training implemented following for example the percent of women with vaginal birth having a 3rd and 4th degree tear.

Managers debriefed and supported staff after any serious incident. The professional midwifery advocate and consultants debriefed staff after serious events. Also, the trust had introduced a pastoral service for staff who may need additional support.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated wll-led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plan to manage them.

Maternity

The structure consists of a divisional director, associate director of operations and head of midwifery with cross divisional head of nursing (paediatrics). They work as a quadrumvirate, with the director of midwifery providing external support via the chief nurse's office.

Maternity safety champions and the non-executive director supports the service. The chief nurse was one of the safety champions who works across obstetrics and neonatal services and was supported by a non-executive director. Their role was to act as ambassadors for safety and facilitate communication from 'floor to board'.

Staff told us that leaders at the Rosie Hospital were visible and approachable in the maternity service. The executive team visited wards on a regular basis and staff informed us of how accessible and encouraging they were. Managers also completed regular walk rounds and staff found them approachable, and keen to hear their views and experiences.

Leaders in the maternity service undertook regular joint working between leaders in other departments, the rest of the trust, partner trusts and with external agencies and bodies to plan and improve care provision for women and babies.

Vision and Strategy

The service had a vision for what it wanted to achieve. A strategy was being developed with all relevant stakeholders.

Cambridge University Hospital had implemented the 'CUH Together 2025' strategy, while the Rosie maternity hospital strategy was still under development in light of the refreshed trust wide strategy. Leaders told us the strategy would be underpinned by:

1. LMNS Strategy – This strategy had not been published yet.
2. Internal Nursing Midwifery and Allied Health Professionals strategy – This strategy was near completion and scheduled to be presented and approved at the governance committee in June/July 2023.

Leaders told us that in 2022, they took an opportunity to forward plan by engaging and consulting with staff, women, birthing people, their families, and partners. The objective was to establish a new trust strategy agenda for the next three years, with a vision to deliver a healthier life for everyone through care, learning, and research. They also emphasised that they would retain their three key strategic trust priorities, which included improving patient care, supporting staff, and building for the future. Furthermore, they had identified 15 commitments aligned with these priorities, reflecting ongoing concerns and specific opportunities.

Culture

Staff felt respected but did not always feel supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff felt respected but did not always feel supported and valued. Most staff were positive about the department, their roles and responsibilities and felt able to speak to leaders about difficult issues and when things went wrong. Results of the last national picker staff survey was completed in 2022 and was summarised based on divisions. The maternity service was under division E which covered medical paediatrics; paediatric critical care and paediatric surgery; obstetrics and gynaecology.

Maternity

A summary score was provided for each division but not maternity service specific. For division E, 51% of staff looked forward to going to work. However, only 52% believed that the organisation takes positive action on their health and well-being. Only 21% of staff were happy with their pay and only 26% of staff said appraisals left them feeling the organisation valued their work.

Although 66% of staff felt safe to speak up about anything that concerns them in the organisation, only 51% felt confident that the organisation would address any concerns they raised. Despite this, 83% of staff felt care of patients in their organisation was top priority.

The trust had a freedom to speak up guardian where staff could get independent support and advice on how to raise concerns. Staff told us they knew who their freedom to speak up guardian was and felt confident to raise a concern with their managers also.

The professional midwifery advocate (PMA) maintained an open-door policy and actively promoted positive working relationships. The primary responsibility of the PMA was to exhibit visible leadership and serve as a role model, ensuring the promotion of effective and safe care and treatment. The PMA actively listened to the concerns and insights of the staff, drawing upon their knowledge, skills, and experience to empower them in both their professional and personal development.

Leaders and staff understood how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. The service recorded people's ethnicity and monitored data to ensure the standard of care was maintained and improved where required. Staff had completed equality, diversity and human rights training and educated on how to identify and reduce health inequalities. The service worked with partner organisations to ensure health inequalities were addressed especially those from ethnic and minority groups. For example, midwives worked in partnership with a traveller health visiting clinics to ensure women and birthing people received the support they required during pregnancy and childbirth.

The service displayed information about how to raise a concern in women and birthing people and visitor areas. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. In 2022, the service carried out a survey to gather women and birthing people's feedback and had only 709 responses out of over 5,000 births. The service updated their feedback process including a quick response (QR) code to encourage more people to feedback about the service. The feedback results were analysed, and themes identified including those of poor care and complaints were identified and addressed. For example, where concerns related to feeding support, the service ensured the appropriate staffing and training was implemented to ensure women and birthing people received the support they required with postnatal care and infant feeding.

Staff understood the policy on complaints and knew how to handle them. Complaints and concerns were handled fairly, and the service used a formal approach to deal with complaints. To improve response time, complaints were allocated to managers in the area of concern who would then investigate the concerns and feedback to the complaints team. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The service received 6 complaints in March 2023 and 7 in April 2023. The complaint log showed themes were identified and most related to communication and clinical treatment.

Staff could give examples of how they used women's feedback to improve daily practice. For example, women and birthing people had complained about time of discharge and to try and keep the time to a minimum. Staff on the postnatal ward had recognised the delays caused in the discharge process and managers were reviewing how they could improve on discharge time. The quality governance committee monitored patient experience and complaints monthly to ensure appropriate processes were in place to address complaints and concerns raised.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff delivered high quality care according to evidence-based practice and national guidance. The service had a process for local policy reviews which was 3 yearly unless important national updates were implemented during that time. The service had an overall 88% compliance to making sure policies, guidelines, procedures, consent forms and patient information leaflets were reviewed on time and leaders met monthly to ensure they had oversight of documents due to expire.

Staff could access policies and procedures electronically when they needed them. Also, within the electronic patient record, staff could access various ‘standard operating procedures’ to help inform their decision making.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a governance structure that supported the flow of information from senior managers to frontline staff.

Staff at all levels were clear about their roles and responsibilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a team, whose prime responsibility was to support clinical governance.

One clinical director oversees women’s health (including gynaecology, maternity and IVF), which oversees gynaecology, fertility, and maternity. Two further clinical directors oversee medical paediatrics, and surgical paediatrics and PICU, under the auspices of the divisional director.

The governance team includes a lead consultant for risk who chairs various departmental service improvement, risk and governance meetings. The safety and governance lead was also a safety champion, and was supported by the quality and patient experience lead, both of whom work with the trust-wide patient safety team to ensure oversight with other divisions within the trust.

The medical director contributed to the review of safety incidents and held joint training sessions for medical staff to support and coach them on the process of incident reporting, outcomes of investigation and how learning was disseminated.

The governance team had a structured meeting process which included monthly governance meetings, weekly rapid review meetings, to look at incidents rated as moderate and above to make sure that any gaps in practice were identified and mitigated.

The Obstetrics and Gynaecology Quality Governance meetings were held monthly. Leaders recorded outcomes from meetings in minutes which showed clear agenda items, attendees, and a traffic light RAG rated system for reviewing changes to practice and making sure they were signed off once implemented. Other regular agenda items included but were not limited to, oversight on the maternity dashboard, urgent issues, pharmacy provision, nursing quality metrics, risk register reviews and serious incidents.

The governance team met bi-monthly with the board level safety champion and the non-executive directors. There was an agenda in place and leaders discussed patient safety incidents, and complaints.

The governance lead gave us examples of quality improvement measures that had been recently implemented to improve and develop the service. The governance team oversaw the bereavement, fetal medicines, and screening teams within maternity. At the time of the inspection the team were training midwives to become bereavement champions and offered several midwives additional training on how to support families around the difficult decisions they faced when thinking about consent for post-mortems. This change to practice had been the result of an incident that occurred and staff spoke passionately about how they wanted to ensure they were advocates for grieving families.

There was a maternity service user voice group (Rosie Maternity and Neonatal Voices Partnership - RMNVP) for maternity services in place. This was overseen by the divisional governance lead, perinatal safety champions, the patient experience groups and the trust quality committee. The RMNVP group had terms of reference and a work plan for maternity. Patient experience insight feeds into the group. This information was gained from patient surveys, friends and family tests, complaints and concerns, the social media pages, quality rounds and the CQC maternity survey. The group feeds information via the trust quality committee and up to board level to ensure service users have a voice.

Also, the service held monthly clinical effectiveness group for obstetric and gynaecological leads to discuss practice.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. These included data submission via the National Perinatal Mortality Review Tool, and the ATAIN (Avoiding Term Admission to Neonatal Units) programme designed to reduce harm leading to newborn admissions to neonatal units for babies born over 37 weeks.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Service leaders developed an annual joint maternity and obstetric audit plan, which was aligned to the specific themes and trends identified during the past year. The most recent plan recorded 44 current audits for the service and six additional entries for proposed audits following the reviews of the trust's key lines of enquiries. Audits were assigned to relevant practice leads or groups and monitored by the obstetric and midwifery divisional audit leads and obstetric and gynaecology clinical effectiveness group.

The service produced data for local audits and reported outcomes to the local authority, the Local Maternity and Neonatal System (LMNS) and various national audits. Most outcomes were in line with national standards. For example, the term babies (over 37 weeks gestation) admission rate to neonatal intensive care units, data for March 2023 showed that the current rate was 4.2%.

Maternity

The massive obstetric haemorrhage (MOH) threshold is 1500ml for either vaginal or instrumental deliveries. Post-partum haemorrhage (PPH) rates were worse than the national average. Records for January to March 2023 showed the average rate for vaginal births, including instrumental deliveries was 6.7% and 2.9% for ceasarean section against a threshold of ≤3.3% and 4.5% respectively. The Trust had a PPH working group, which was clinically-led, monitoring improvement plans.

The current rate for pre-term birth was 7.6% (childbirth before 37 weeks of pregnancy). One of the key factors for this rate was because the trust is a tertiary centre for neonatal care and has a level 3 neonatal intensive care unit. This meant that women at risk of extreme pre-term birth were transferred from other hospitals in the region to deliver their babies, so that specialist care could be provided.

The maternity dashboard data showed that the services performance in the management of planned inductions of labour fell short of targets. Data from NICE 'Red Flag' Incident reports showed that from April 2022 to March 2023 on average women and pregnant people experienced long delays to the commencement of labour, performance for the year showed that 32% of women each month had their induction delayed. The impact of this is potential impact on the well-being on the unborn baby. Doctors reviewed each patient before informing them of delays and the service was reviewing the estates to increase capacity.

Managers and staff used the results to improve women's outcomes. Managers used audit data to inform the training programme and for quality improvement purposes. One example of this was the postpartum haemorrhage rates, because these were higher than the national average, maternity leaders had implemented additional training and processes to make sure they had insight into the reasons why the rates were high and how they could improve outcomes. For example, managers in the maternity assessment unit had introduced an 'Iron Infusion' Clinic for women who required additional iron supplements to make sure their bodies were healthy for labour.

Managers shared and made sure staff understood information from the audits. Throughout the maternity unit, managers updated maternity safety and quality white boards. The information on the boards included but was not limited to; details of the most recent policy updates, details of updates to practice like the services plans to reduce postpartum haemorrhage (PPH) rates. The maternity dashboard was displayed so that staff understood the performance and outcomes for women and pregnant people who accessed the service.

Improvement was monitored. Various reports like the East of England Regional Perinatal Quality Oversight Group Highlight Report, the Quality Governance meeting report, the quality committee report and the trust wide Integrated Quality, Performance, Finance and Workforce report confirmed that improvement was monitored and fed into quality improvement initiatives.

The service was accredited by the NHS Resolution. The service achieved compliance to all 10 of the Clinical Negligence Scheme for Trusts (CNST) and the Maternity incentive Schemes safety standards and reported this to the trust board in January 2023.

The service made sure that ethnicity data was captured as part of the incident reporting and review process.

The maternity risk register showed 49 current risks to the service. Risks were scored and RAG rated using a traffic light system, for example there were 13 green risks which scored under 6 points, 13 amber risks and 6 red risks.

The local risk register fed into the corporate risk register for those risks that scored 16 and above, Records showed 3 risks for maternity were:

1. Lack of staffing capacity in maternity services to meet the elective caesarean demand
2. Medical Staffing vacancies at middle and consultant grade impacting coverage
3. Midwifery staff skill mix impacting patient experience or the capacity and therefore the need to go to divert.

All 3 risks stated the rationale for the risks, identified gaps in control and provided assurance in the form of current actions. For example, updates in workforce planning to address the birth rate and the recommendations within the maternity improvement plan.

The trust-wide quality committee met bi-monthly to review key areas of concern and make sure they had oversight of quality and safety throughout the hospital. Reports showed that leaders received updates from the maternity service. Items discussed in the March 2023 report were the current vacancy rates, the 3-year delivery plan for maternity and neonatal services which was published in 2023. Also discussed was the Maternity Quality Improvement Plan which combined workstreams from various national report recommendations like, the Ockenden (2022) recommendations, the Kirkup (2022) and the maternity self-assessment, which fed into overarching plans.

The perinatal safety champions met monthly to review safety throughout maternity and the neonatal unit. Minutes from January 2023 showed that the obstetric safety champion provided a summary of key concerns around staffing shortfalls, in particular senior registrars. The midwifery safety champion updated the team on the patient experience, the Kirkup gap analysis, the Ockenden actions and the maternity safety improvement group. A key challenge in relation to compliance with the Ockenden recommendations included updating the digital patient record with improved risk assessments to support identification of lead professional and intended place of birth.

Safety champions also discussed the Perinatal Mortality Review from May to December 22 and noted there were no key concerns to report.

Information Management

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

The maternity service collected reliable data and analysed it. they had clear performance measures and key performance indicators (KPIs) in place, and these were effectively monitored. This included a maternity dashboard and quality, performance, finance, and workforce KPIs; this information was accessible to senior managers. Information was used to measure performance and drive improvement.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service had embedded an electronic records system and staff accessed and updated electronic patient records including booking appointments, screening results, medicines and updating safeguarding information. The service recently introduced an electronic handover board. Staff spoke positively about how it had helped improve patient care and information sharing.

The information systems were integrated and secure. Staff password protected devices to ensure information was kept confidential.

Leaders submitted information and data to external organisations as required. The service submitted data sets to the perinatal, mortality review tool (PMRT), clinical negligence scheme for trusts (CNST) and CQC.

Engagement

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

The maternity service established systems for engaging with internal and external stakeholders. The trust was an active partner in the Local Maternity and Neonatal System (LMNS), collaborating with other local maternity units to ensure safer and personalised care for women. Within the LMNS, there was a culture of shared learning and the exchange of good practices across the region. The aim was to enhance the consistency of safe care and provide pregnant women and birthing people access to up-to-date evidence to make informed choices about their care.

The service actively collaborated with the Maternity and Neonatal Voices Partnership (MNVP) to improve on patient care by gathering and incorporating feedback from both patients and staff. The MNVP support in planning, reviewing, updating, and influencing policies, as well as participating in the co-production of informational materials. The service leaders fostered meaningful relationships with the MNVP, valuing their input and facilitating regular communication with staff and senior leadership.

The maternity service partnered with the MNVP to gather feedback, reach, and bridge gaps to underserved communities by using social media platforms and community engagement initiatives. The MNVP organised listening events, some tailored towards specific groups, including non-English speaking families, young mothers, fathers, or birthing partners, to ensure diverse views were considered. There was a focus on engaging hard-to-reach communities, such as the travelling communities and individuals with low literacy or limited English proficiency. Additionally, the MNVP advocated for patients who felt unheard. For example, working with staff to ensure people were supported appropriately during intrapartum care.

Leaders established meaningful relationships with the local MNVP, enabling them to actively participate as equal partners in meetings. The MNVP's were passionate about their role, engagement with the service, and had a positive impact on women and birthing partners who accessed the service. They had regular meetings with leaders and staff to co-produce for example choice and consent, communication guide and additional infant feeding support. They also reviewed externally produced documents including the CQC national maternity survey 2022 and completed actions on induction of labour, understanding reduced fetal movement and perinatal mental health.

Staff expressed positive views about the RMNVP engagement and felt supported in reaching out to them. The RMNVP had links with the quality and patient experience lead midwife, they had quarterly meetings with obstetricians to gather their views about patient care. The MNVP knew about concerns relating to the elective caesarean list and the lack of adequate medical staffing and the impact this was having on patient experiences.

Leaders valued the partnership with the MNVP and closely monitored their level of involvement and engagement. For example, the trust involved MNVP as equal partners to explore women's options around the safe use of Entonox (gas and air). They informed us the service was responsive and proactive in improving patient care. However, the service needed to improve interpreting services for women and birthing people so that vital information was not lost in translation, which could lead to poor care outcomes.

To drive further improvement and encourage partnership working, a local ‘birth as a medium for change group’ Cambridge social care, Cambridgeshire women's resource centre and Cambridgeshire included doulas. This group aims to improve, outcomes for women and birthing people’ through doula care and partnership working.

The service sought staff views to inform practice and patient care. Leaders engaged with staff through various staff meetings, forums, listening events and newsletters. Staff were empowered to raise concerns and provide suggestions and feedback to drive improvements. For example, staff provided feedback on areas including staffing levels, annual leave, on-call, breaks and self-rostering. Staff were also provided information on the support available, training and how they could improve practice and their personal and professional development.

The service engaged with key organisations including partner NHS trusts, local authorities, and charities to improve on patient outcomes.

Learning, continuous improvement and innovation

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

Leaders and staff were committed to continually learn, improve, and innovate services by learning from when things went well or not so well by making changes to practice through shared learning, training and innovation.

The service had a dedicated research department that worked closely with the University of Cambridge and carried out medical research related to women’s reproductive health, pregnancy, labour and newborn babies' health and well-being. Their aim was to provide better outcomes for women, birthing people, and their babies.

The service had systems in place to improve on the service. A maternity quality improvement plan was in place and was last updated in April 2023. Leaders used this plan to monitor progress for example on the service’s compliance with actions relating to risk assessment, cross border booking for out of area women so they could complete actions from the final Ockenden review.

Leaders attended regular maternity and neonatal safety improvement programme optimising working party meetings to discuss improvements that could be made to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth. Areas of discussions included the safe administration of steroids and fetal movement.

In 2022 the service signed for the national bereavement care pathway to demonstrate their commitment to high quality care for people experiencing pregnancy loss or the death of a baby in the service or the trust as a whole. The maternity service worked in collaboration with women, birthing people, and their partners to improve the quality and consistency of bereavement care. Bereavement champions were appointed, and support was provided to new staff to understand bereavement care. The service participated in national campaigns to create awareness including the “Baby Loss Awareness Week” and worked in partnership with key charities to help families navigate their loss.

In May 2022, the service together with NHS Blood and Transplant launched fetal RHD screening this was meant to identify Rh compatibility between pregnant women and birthing people and their fetus and to provide support to avoid unnecessary prenatal treatment.

Maternity

The maternity service also offers “IV Iron Clinic” to support women living with anaemia in pregnancy due to iron deficiency. In line with the National Institute of Clinical Excellence (2021) recommends where oral iron for any woman and birthing person with anaemia during pregnancy was not effective, an IV iron was offered reduce complications in such as premature birth in pregnancy.

As per CNST and ATAIN requirements, leaders held quarterly meetings to discuss audits on the care provided to babies receiving transitional care on the postnatal ward and made actions for improvement.

Outstanding practice

We found the following outstanding practice:

- The service had a strong working relationship with the maternity and neonatal voices partnership (MNVP). They were active in gathering people’s views about the service to improve patient experiences. They worked in partnership with the service to influence policies, engaged in various projects to drive improvement including co-producing information leaflets and challenge practice where this was required.
- The maternity service also offers an “IV Iron Clinic” to support women living with anaemia in pregnancy due to iron deficiency. In line with the National Institute of Clinical Excellence (2021) recommendations, where oral iron for any woman and birthing person with anaemia during pregnancy was not effective, intravenous iron infusion should be offered to reduce complications such as premature birth in pregnancy.
- The service had a 'close observation unit' to provide additional medical support to women and birthing people that needed continuous monitoring and care.

Areas for improvement

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

MUSTS

The Rosie Hospitals - Maternity

- The trust must ensure that there are enough suitably qualified competent staff to meet the needs of the service and any shortfall is mitigated as much as possible. (Regulation 18(1)(2))

SHOULDS

The Rosie Hospitals - Maternity

- The trust should ensure that medical staffing in triage is reviewed and improved to deliver care in safe time frames and complete regular audits on waiting times for doctor reviews.
- The service should ensure that it makes improvements to the induction of labour process so that women and pregnant people do not experience the current level of delays cited in annual data.

Maternity

- The service should ensure that it continues to make the necessary improvements and implement administrative staff to the triage area so that access and flow are improved especially in the afternoons and evenings.
- The trust should ensure that there is a designated ‘triage’ line so that women in the most need of help and advice are able to contact the service within safe timeframes.
- The service should consider reviewing the signage to each department and consider changing the ward names, so they reflect the nature of each department.
- The service should continue to look at strategies and training to improve the postpartum haemorrhage rate.
- The service should ensure the electronic records management system had the ability to transfer electronic patient record from multiple systems and community and could be reorganised easily to meets the needs of patients.
- The service should ensure appropriate prearranged translation service was available for non-English speaking women and birthing people.
- The service should ensure to improve on their post-partum haemorrhage rates for both vaginal births and instrumental deliveries.
- The service should ensure to improve on the commencement of planned inductions of labour.
- The service should continue to improve staff compliance to completing VTE assessments in line with national guidance.
- The service should ensure that it completes regular audits on compliance of fetal monitoring during labour.
- The service should improve staff training and appraisal rates to ensure staff are competent in their roles.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors, 2 midwifery specialist advisors and one obstetrician. Carolyn Jenkinson deputy director of secondary and specialist care oversaw the inspection team.