

Walsall Healthcare NHS Trust Manor Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Maternity (inpatient services)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust serves a population of around 270,000. Acute hospital services are provided from one site, Walsall Manor Hospital. Walsall Manor Hospital has 550 acute beds. There is a separate midwifery-led birthing unit (this is currently not operating), and the trust's palliative care centre in Goscote is their base for a wide range of palliative care and end of life services.

The trust was placed in special measures by the Secretary of State for Health in February 2016 following our announced comprehensive inspection in September 2015.

After a further inspection in June 2017 the Care Quality Commission served the trust with a Section 29a Warning Notice of the Health and Social Care Act 2008. This outlined the quality of healthcare provided by Walsall Healthcare NHS Trust for the following regulated activities required significant improvement:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

The warning notice set out the points of concern and timescales to address this and was wholly related to maternity services. The trust responded to this with a detailed plan for remedial action.

This inspection was an unannounced focussed follow-up inspection of maternity services on 5, 6 and 12 June 2018. The purpose of our inspection was to determine if the maternity service at Walsall Healthcare NHS Trust had made the improvements we highlighted were required following our 2017 inspection and establish if work had progressed to meet the requirements of the warning notice.

During this inspection, we visited all areas of the maternity service at Manor Hospital. We did not inspect community midwifery services or the standalone midwifery led unit.

We spoke with nine patients and relatives, and 32 staff members at all levels, including consultants, midwives, student midwives, maternity support workers and administration staff.

We reviewed 20 prescription charts and 17 patient medical records.

A range of data was requested from the trust as part of this inspection.

We also held maternity staff focus groups for all staff levels and community staff following the inspection to give staff the opportunity to feedback about the service. In total, there were 46 attendees.

We rated this service as requires improvement because:

- The number of never events had increased in the service from no never events between June 2016 to June 2017 to two never events for the following year.
- The service did not effectively address the findings from audits to demonstrate effective management of infection control risks.
- Overall, the incident reporting process had improved however, further improvement was still required as staff told us feedback from incident investigations was not always shared with staff and action plans were not always circulated to all appropriate staff.
- Breastfeeding support provision for patients was insufficient.

Summary of findings

- Fridges to store breast milk were unsecured during our inspection. The service addressed this in a timely way however, there was not a process in place to ensure these fridges remained locked.
 - There had not been any recent infant abduction drills conducted.
- The service did not always ensure vaccination provision was sufficient to protect women and their babies.
- There was limited availability of accessible information in different languages, picture formats, and cue cards. The use of the translation phone service was variable and did not always protect patient privacy.
- The service did not currently have any internal services dedicated for counselling parents who had experienced the loss of a baby.
- The closure of the midwifery led unit in July 2017 had improved staffing levels in the acute setting however, women who may have chosen to birth in the MLU may not have access to the same facilities and equipment to support a normal birth on the main site.
- Leaders recognised further leadership improvements were required however, we were not wholly assured the pace of change was sufficient to drive improvement in a timely way.
- Some long-standing midwives felt excluded as they perceived they had fewer opportunities than recently recruited midwives.
- Some cultural issues remained an issue with some pockets of staff and reports of staff undermining other staff. The coherence of some consultants required further improvement.
- Some staff felt they were not sufficiently involved in discussions regarding the closure of the MLU. However, we saw a phased plan to re-open the MLU to accept patients to birth there.
- The maternity improvement action plan did not sufficiently document specific individual actions identified by the 2017 CQC report or external reviews of culture in the maternity service.
- Service leaders did not sufficiently prioritise or support the normality agenda.
- Governance was more organised and process driven but there was still a long way to go to be fully functional by ensuring all staff were fully engaged with the governance process of the department.
 - Improvements in the sustainability of the service and improved staffing levels in the hospital setting had been partly achieved by having a birth cap in place and by closing the midwifery led unit. We had concerns that the service may not be sustainable if the unit was delivering to its capped level and the midwifery led unit re-opened.

The service had made improvements against all of the concerns we raised in the 2017 warning notice:

- Monitoring, recording and escalation of concerns for Cardiotocography (CTG)
- Insufficient numbers of midwives with HDU training to ensure that women in HDU are cared for by staff with the appropriate skills.
- Safeguarding training was insufficient to protect women and babies on the unit who may be at risk.
- There were insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards

At this inspection, we saw the following improvements for maternity services:

- Maternity staff safeguarding training compliance rates had significantly improved since our last inspection. As of 30 May 2018, midwives and support staff and medical staff safeguarding training compliance exceeded the trust target of 90% for all levels of adult and children's safeguarding they were required to conduct.
- Midwifery staffing levels had significantly increased since the last inspection.
- Between May 2017 and April 2018, mandatory training rates had improved across the service.
- The service had reduced the average combined elective and emergency caesarean section rate since the last inspection.
- Maternity staff fully completed early warnings scores consistently well and could identify a patient's deterioration.

Summary of findings

- Overall, patients reported positive care experiences.
- We observed all staff interactions with patients were caring and supportive.
- Patients received compassionate and supportive care for as long as they needed.
- The bereavement midwife offered patients emotional support following pregnancy loss.
- The transitional care service was an innovative and dedicated approach to postnatal care.
- Since the last inspection, the service now had a leadership structure in place with clear lines of escalation. The corporate leadership team and frontline staff were more linked and confidence in leaders had improved.
- Overall, consultants were now more engaged with the improvement process in maternity services.
- Service leaders and members of the trust's executive team demonstrated they had improved oversight of the challenges the maternity service was facing.
- Staff felt their contributions to the maternity service were more valued by the senior leadership team.
- Community staff told us they felt well supported by the community leaders who formed part of the changed leadership structure.
- Junior doctors told us the maternity leadership team were approachable and they felt comfortable to raise issues with the Clinical Director if necessary.
- The maternity service leaders had developed a clearer vision and strategy for the service in place compared to our previous inspection. This included expanding the bereavement service provision.
- Senior staff were most proud of the improvement in staff morale and staff engagement in the improvement journey of the service.
- The local maternity risk register accurately documented the main risks to the service.
- A new purpose built second theatre was being constructed which mitigated risks identified at our previous inspection relating to the
- Following the inspection, we saw evidence the service had implemented procedures to manage staff who were openly not adhering to guidelines and procedures.
- The maternity service supported a multidisciplinary forum 'Walsall Maternity Voices Partnership' which met bi-monthly.
- The maternity service had been nominated for an award in transitional care.

We saw several areas of outstanding practice including:

- Funding had been secured for 170 midwives to conduct PHI learning. This learning is endorsed and supported by the Royal College of Midwives.
- The transitional care service was an innovative and dedicated approach to postnatal care.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure information in different languages, picture formats, and cue cards are available to patients.

In addition, the trust should:

- Ensure all staff complete mandatory training as required for their role.
- Ensure actions on action plans to address non-compliance for infection prevention and control are followed through.
- Ensure regular infant abduction exercises are conducted in the department to check for any gaps in the process and assess staff awareness of their role.
- Ensure gases were stored with the required signage on the doors
- Ensure processes are in place to store breast milk safely.

Summary of findings

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Maternity (inpatient services)

Requires improvement



Rating

Why have we given this rating?

We rated maternity services as requires improvement because:

- The number of never events had increased in the service from no never events between June 2016 to June 2017 to two never events for the following year.
- The service did not effectively address the findings from audits to demonstrate effective management of infection control risks.
- Overall, the incident reporting process had improved however further improvement was still required as staff told us feedback from incident investigations was not always shared with staff and action plans were not always circulated to all appropriate staff.
- Breastfeeding support provision for patients was insufficient.
- Fridges to store breast milk were unsecured during our inspection. The service addressed this in a timely way however, there was not a process in place to ensure these fridges remained locked.
- There had not been any recent infant abduction drills conducted.
- The closure of the midwifery led unit in July 2017 had improved staffing levels in the acute setting however, women who may have chosen to birth in the MLU may not have access to the same facilities and equipment to support a normal birth on the main site.
- There was limited availability of accessible information in different languages, picture formats, and cue cards. The use of the translation phone service was variable and did not always protect patient privacy.
- The service did not currently have any internal services dedicated for counselling parents who had experienced the loss of a baby.
- Leaders recognised further leadership improvements were required, we were not wholly assured the pace of change was sufficient to drive improvement in a timely way.

Summary of findings

- Some long-standing midwives felt excluded as they perceived they had fewer opportunities than recently recruited midwives.
- Some cultural issues remained an issue with some pockets of staff and reports of staff undermining other staff. The coherence of some consultants required further improvement.
- Some staff felt they were not sufficiently involved in discussions regarding the closure of the MLU. We did not see a plan in place to re-open the MLU to accept patients to birth there.
- Senior staff needed to continue to accept and address the concerns identified in maternity services and maintain the pace of change.
- The maternity improvement action plan did not sufficiently document specific individual actions identified by the 2017 CQC report or external reviews of culture in the maternity service.
- Service leaders did not sufficiently prioritise or support the normality agenda.
- Governance was more organised and process driven but there was still a long way to go to be fully functional by ensuring all staff were fully engaged with the governance process of the department.
- Improvements in the sustainability of the service and improved staffing levels in the hospital setting had been partly achieved by having a birth cap in place and by closing the midwifery led unit. We had concerns that the service may not be sustainable if the unit was delivering to its capped level and the midwifery led unit re-opened.

However, we saw the maternity service had made some improvements since our last inspection.

- Maternity staff safeguarding training compliance rates had significantly improved since our last inspection. As of 30 May 2018, midwives and support staff and medical staff safeguarding training compliance exceeded the trust target of 90% for all levels of adult and children's safeguarding they were required to conduct.
- Midwifery staffing levels had significantly increased since the last inspection.
- Between May 2017 and April 2018, mandatory training rates had improved across the service.

Summary of findings

- Maternity staff fully completed early warnings scores consistently well and could identify a patient's deterioration.
- The service had reduced the average combined elective and emergency caesarean section rate since the last inspection.
- Overall, patients reported positive care experiences.
- We observed all staff interactions with patients were caring and supportive.
- Patients received compassionate and supportive care for as long as they needed.
- The bereavement midwife offered patients emotional support following pregnancy loss.
- The transitional care service was an innovative and dedicated approach to postnatal care.
- Since the last inspection, the service now had a leadership structure in place with clear lines of escalation. The corporate leadership team and frontline staff were more linked and confidence in leaders had improved.
- Overall, consultants were now more engaged with the improvement process in maternity services.
- Service leaders and members of the trust's executive team demonstrated they had improved oversight of the challenges the maternity service was facing.
- Staff felt their contributions to the maternity service were more valued by the senior leadership team.
- Community staff told us they felt well supported by the community leaders who formed part of the changed leadership structure.
- Junior doctors told us the maternity leadership team were approachable and they to felt comfortable to raised issues with the Clinical Director if necessary.
- The maternity service leaders had developed a clearer vision and strategy for the service in place compared to our previous inspection. This included expanding the bereavement service provision.
- Senior staff were most proud of the improvement in staff morale and staff engagement in the improvement journey of the service.

Summary of findings

- The local maternity risk register accurately documented the main risks to the service.
 - A new purpose built second theatre was being constructed which mitigated risks identified at our previous inspection relating to the
 - Following the inspection, we saw evidence the service had implemented procedures to manage staff who were openly not adhering to guidelines and procedures.
 - The maternity service supported a multidisciplinary forum 'Walsall Maternity Voices Partnership' which met quarterly.
 - The maternity service had been nominated for an award in transitional care.
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Manor Hospital

Detailed findings

Services we looked at

Maternity (inpatient services);

Detailed findings

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Background to Manor Hospital

The trust provides acute hospital services from one main site, Walsall Manor Hospital and at the time of our inspection, the trust had 550 acute beds.

This trust is not a foundation trust and this inspection did therefore not form part of a foundation trust application.

The trust was placed in special measures by the Secretary of State for Health in February 2016 following our announced comprehensive inspection in September 2015

The trust board had seven Non-Executive Directors, including the Chair and two associate Non-Executive Directors. The Chief Executive Officer had been in post since February 2018.

When we inspected the trust, the Chair of the board had been in post since April 2016, the director of nursing post was vacant, with the deputy director of nursing acting up whilst active recruitment was taking place. The previous interim director of nursing vacated the post in May 2018.

The trust launched their five-year strategic plan in 2016 following engagement with the board, operational care groups and staff at the trust. The trust's goal for this strategy is 'becoming your partners for first class integrated care'. Delivering the trust's vision and strategic objectives was an ongoing priority for the trust.

Our inspection team

Our inspection team was led by:

Bridgette Hill: Inspection Manager, Care Quality Commission

The inspection team also included two CQC inspectors, one maternity specialist advisor and a CQC National Professional Advisor.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well-led?
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Detailed findings

Before we inspected the trust, we reviewed a range of information we held about Walsall Healthcare NHS Trust and a range of data was requested from the trust as part of this inspection.

We conducted an unannounced focussed follow-up inspection of maternity services on 5, 6 and 12 June 2018. The purpose of our inspection was to determine if the maternity service at Walsall Healthcare NHS Trust had made the improvements we highlighted were required following our 2017 inspection.

During this inspection, we visited all areas of the maternity service at Manor Hospital. We did not inspect community midwifery services or the standalone midwifery led unit.

We spoke with nine patients and relatives, and 32 staff members at all levels, including consultants, midwives, student midwives, maternity support workers and administration staff.

We reviewed 20 prescription charts and 17 patient medical records.

We also held maternity staff focus groups for all staff levels and community staff following the inspection to give staff the opportunity to feedback about the service. In total, there were 46 attendees.

Facts and data about Manor Hospital

Walsall Healthcare NHS Trust is the only provider of NHS acute care in the Walsall borough, providing inpatient and outpatient services at the Manor Hospital as well as adult, children and young people and end of life care services in the community. This trust has one acute location, Manor Hospital. It also operates from a number of community locations.

The trust serves a population of approximately 270,000 people.





The health of people in Walsall is worse than the England average. Deprivation is worse than the England average and about 15,000 children live in poverty. Life expectancy for both men and women is significantly worse than the England average. Walsall has a higher than average

number of teenage pregnancies within its population. Walsall ranks 33rd out of 326 local authorities for deprivation (where 1 is the most deprived and 326 is the least deprived). (Deprivation in Walsall: Summary Report, Sept 2015). Walsall had three out of seven disease and poor health indicators that were worse than the England average.

Maternity services activity:

There were 4135 babies born on the delivery suite at Walsall Healthcare NHS Trust between April 2016 and March 2017 and 228 babies born at the maternity led unit. Between May 2017 and April 2018, there had been 3,577 babies born at the trust.

Maternity (inpatient services)

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Walsall Healthcare NHS Trust provides maternity services in both acute and community settings.

Maternity services at the Manor Hospital offer a consultant-led delivery suite, a fetal assessment unit (FAU), a triage area, an induction of labour area, outpatient antenatal clinics and an antenatal and postnatal inpatient ward.

A standalone midwifery led unit (MLU) is situated a mile away from the main hospital. The MLU had been closed since July 2017 due to shortfalls in staffing numbers across maternity services. At the time of our inspection, this unit was not open for women to give birth there and did not form part of our inspection.

The community midwifery teams provide maternity services alongside general practitioners and health visitors. Community midwives provide antenatal care, postnatal care in children's centres, GP surgeries and in patient's own homes.

The maternity department at Walsall Healthcare NHS Trust has a cap on the number of births set at 4,200 births per year. This has been in place since March 2016 following discussions between leaders of the maternity service and stakeholders regarding shortfalls in staffing numbers and increased demand for maternity services. The service also had an agreement with a neighbouring trust to take 500 of their patients to birth at their trust.

There were 4,135 babies born on the delivery suite at Walsall Healthcare NHS Trust between April 2016 and March 2017 and 228 babies born at the maternity led unit. Between May 2017 and April 2018, there had been 3,577 babies born at the trust.

We conducted a focussed follow-up inspection of maternity services at Walsall Healthcare NHS Trust on 5,6 and 12 June 2018. We rated this service as requires improvement overall. We rated the caring domain as good and the safe, effective, responsive and well led domains were all rated as requires improvement.

During this inspection, we visited all areas of the maternity service at Manor Hospital. We did not inspect community midwifery services or the standalone midwifery led unit. However, we did speak with community midwives.

We spoke with nine patients and relatives and 32 staff members at all levels, including consultants, midwives, student midwives, maternity support workers and administration staff.

We reviewed 20 prescription charts and 17 patient medical records.

We also held maternity staff focus groups for all staff levels and community staff following the inspection to give staff the opportunity to feedback about the service. In total, there were 46 attendees.

Maternity (inpatient services)

Summary of findings

During our last inspection of maternity and gynaecology services in June 2017, we rated this service as inadequate overall. The safe and well led domains were both rated inadequate and effective, caring and responsive domains as requires improvement. All of the concerns raised during the previous inspection applied to maternity services and did not include gynaecology.

We conducted an unannounced focussed follow-up inspection of maternity services on 5, 6 and 12 June 2018. The purpose of our inspection was to determine if the maternity service at Walsall Healthcare NHS Trust had made the improvements we highlighted were required following our 2017 inspection.

The overall rating for maternity services was requires improvement. We rated the caring domain as good and the safe, effective, responsive and well led domains were all rated as requires improvement.

We rated this service as requires improvement overall because:

- The number of never events had increased in the service from no never events between June 2016 to June 2017 to two never events for the following year.
- The service did not effectively address the findings from audits to demonstrate effective management of infection control risks.
- Overall, the incident reporting process had improved. However further improvement was still required as staff told us feedback from incident investigations was not always shared with staff and action plans were not always circulated to all appropriate staff.
- Breastfeeding support provision for patients was insufficient.
- There had not been any recent infant abduction drills conducted.
- Fridges to store breast milk were unsecured during our inspection. The service addressed this in a timely way however, there was not a process in place to ensure these fridges remained locked.

- There was limited availability of accessible information in different languages, picture formats, and cue cards. The use of the translation phone service was variable and did not always protect patient privacy.
- Some staff told us the senior maternity team and consultants did not have the discharge process as a priority.
- The service did not currently have any internal services dedicated for counselling parents who had experienced the loss of a baby.
- The closure of the midwifery led unit in July 2017 had improved staffing levels in the acute setting however, women who may have chosen to birth in the MLU may not have access to the same support for a normal birth on the main site.
- Leaders recognised further leadership improvements were required, we were not wholly assured the pace of change was sufficient to drive improvement in a timely way.
- Some long-standing midwives felt excluded as they perceived they had fewer opportunities than recently recruited midwives.
- Some cultural issues remained an issue with some pockets of staff and reports of staff undermining other colleagues. The coherence of some consultants required further improvement.
- Some staff felt they were not sufficiently involved in discussions regarding the closure of the MLU. We did not see a plan in place to re-open the MLU to accept patients to birth there.
- Senior staff needed to continue to accept and address the concerns identified in maternity services and maintain the pace of change.
- The maternity improvement action plan did not sufficiently document specific individual actions identified by the 2017 CQC report or external reviews of culture in the maternity service.
- Service leaders did not sufficiently prioritise or support the normality agenda.

Maternity (inpatient services)

- Governance was more organised and process driven but there was still a long way to go to be fully functional by ensuring all staff were fully engaged with the governance process of the department.
- Improvements in the sustainability of the service and in particular improved staffing levels in the hospital setting had been partly achieved by having a birth cap in place and closing the midwifery led unit. We had concerns that the service may not be sustainable if the unit was delivering to its capped level and the midwifery led unit re-opened.

However, we saw the maternity service had made some improvements since our last inspection.

- Maternity staff safeguarding training compliance rates had significantly improved since our last inspection. As of 30 May 2018, midwives and support staff and medical staff safeguarding training compliance exceeded the trust target of 90% for all levels of adult and children's safeguarding they were required to conduct.
- Midwifery staffing levels had increased since the last inspection. Staffing levels were sufficient for the current birth rate, however, there may not be enough staff if the department was delivering to its capped level and if the midwifery led unit re-opened for women to give birth there.
- Staff monitored, recorded and escalated concerns regarding cardiotocography (CTG) reviews to protect women and their babies from abuse and avoidable harm.
- Between May 2017 and April 2018, mandatory training rates had improved across the service.
- Maternity staff fully completed early warnings scores consistently well and could identify a patient's deterioration.
- The service had reduced the average combined elective and emergency caesarean section rate since the last inspection.
- Overall, patients reported positive care experiences.
- We observed all staff interactions with patients were caring and supportive.

- Patients received compassionate and supportive care for as long as they needed.
- The bereavement midwife offered patients emotional support following pregnancy loss.
- The transitional care service was an innovative and dedicated approach to postnatal care.
- Since the last inspection, the service now had a leadership structure in place with clear lines of escalation. The corporate leadership team and frontline staff were more linked and staff confidence in their leaders had improved.
- Overall, consultants were now more engaged with the improvement process in maternity services.
- Service leaders and members of the trust's executive team demonstrated they had improved oversight of the challenges the maternity service was facing.
- Staff felt their contributions to the maternity service were more valued by the senior leadership team.
- Community staff told us they felt well supported by the community leaders who formed part of the changed leadership structure.
- Junior doctors told us the maternity leadership team were approachable and they felt comfortable to raised issues with the Clinical Director if necessary.
- The maternity service leaders had developed a clearer vision and strategy for the service compared to our previous inspection. This included expanding the bereavement service provision.
- Senior staff were most proud of the improvement in staff morale and staff engagement in the improvement journey of the service.
- The local maternity risk register accurately documented the main risks to the service.
- A new purpose built second theatre was being constructed which mitigated risks identified at our previous inspection relating to the second theatre being unfit for purpose.

Maternity (inpatient services)

- Following the inspection, we saw evidence the service had implemented procedures to manage staff who were openly not adhering to guidelines and procedures.
- The maternity service supported a multidisciplinary forum 'Walsall Maternity Voices Partnership' which met quarterly.
- The maternity service had been nominated for an award in transitional care.

Are Maternity (inpatient services) safe?

Requires improvement 

We rated safe as requires improvement because:

- The number of never events had increased in the service from no never events between June 2016 to June 2017 to two never events for the following year.
- The service did not provide all women in labour with one-to-one care.
- Overall, the incident reporting process had improved however further improvement was still required as staff told us feedback from incident investigations was not always shared with staff and action plans were not always circulated to all appropriate staff.
- The service did not effectively address the findings from audits to demonstrate effective management of infection control risks.
- Cardiotocography training rates were below the trust target.
- PROMPT training compliance for band 2,3 4 staff and medical staff were below the trust target.
- PREVENT level 3 training compliance rates were below the trust target.
- Fire safety risk assessments did not accurately reflect some of the risks and did not take into account significant changes on the antenatal and postnatal wards.
- There had not been any recent infant abduction drills conducted.

However:

- Midwifery staffing levels had increased since the last inspection and were sufficient for the current birth rate, but may be insufficient if the unit was delivering to its capped level and the MLU re-opened.
- Staff monitored, recorded and escalated concerns regarding cardiotocography (CTG) reviews to protect women and their babies from abuse and avoidable harm.

Maternity (inpatient services)

- Between May 2017 and April 2018, mandatory training rates had improved across the service.
- Safeguarding training rates had significantly improved since our last inspection. As of 30 May 2018, midwives and support staff and medical staff safeguarding training compliance exceeded the trust target of 90% for all levels of adult and children's safeguarding they were required to complete.
- The trust had clear FGM reporting and information sharing arrangements with other agencies.
- Maternity staff fully completed early warnings scores consistently well and could identify a patient's deterioration.
- Maternity staff consistently completed venous thromboembolism risk assessments.
- World Health Organisation (WHO) surgical safety 'Five Steps to Safer Surgery' checklist audit results in the maternity theatre were consistently 100% for 11 of the 12 months.
- The service managed and disposed of medication and controlled drugs safely and in accordance with the trust's guidance.
- Records were securely stored and well organised.

Mandatory training

- Staff completed their mandatory training through face-to-face sessions and online courses. Midwives and medical staff attended an update study day each year.
- The continuing professional development midwife designed and co-ordinated training to ensure the training content was in line with staff training needs, was evidence-based, consistent with national and local guidance and adapted in response to incidents.
- Senior staff monitored mandatory training compliance each month. The trust set a target of 90% for mandatory training completion. From May 2017 to April 2018, the trend for completion of mandatory training showed improvement overall for both nursing and midwifery staff and medical staff. For the first eight months, the trust did not meet its target for nursing and midwifery staff. This ranged from 78% to 87%. However, from January 2018 to April 2018, the trust exceeded its target for nursing and midwifery staff at 92%, 93%, 91% and

91% respectively. During the same time period, medical staff did not meet the trust target for any months. The lowest compliance rate was at 54% in August 2017 however, rates had improved to their highest rate of 79% in April 2018.

- All maternity staff told us senior staff supported them to complete their mandatory training. However, staff told us they were sometimes unable to attend training sessions as they had to prioritise shifts to be covered. The service had implemented measures to address non-compliance; senior staff monitored training rates regularly. The continuing practice development midwife planned study days two months in advance to give staff advance notice of forthcoming training in an attempt to improve training compliance rates. They would also email the manager of staff who did not attend training and take disciplinary action if required.
- All midwives were required to complete annual mandatory cardiotocography (CTG) training as part of nationally recognised fetal monitoring training programme (K2). As of April 2018, the number of maternity staff who had completed interpretation and escalation training as part of fetal monitoring training was 81%. This was below the 90% target. For the remaining months from August 2017 to March 2018, compliance ranged from its lowest rate at 70% in August 2017 to its highest compliance rate in February 2018 at 89%. This training included for example, antenatal and intrapartum CTG and fetal physiology. Maternity staff were required to complete competency assessments for each chapter to demonstrate their CTG reviewing competency levels.
- The service demonstrated improvements had been made in respect of the CTG monitoring issues identified as part of the 2017 warning notice and during our 2017 inspection. However, as CTG training rates were below the trust target, we were not assured leaders of the service had prioritised staff completion of CTG training sufficiently.
- All maternity staff were required to conduct PROMPT (PRactical Obstetric Multi-Professional Training) skills and drills training each year as recommended by national guidance. Skills and drills were held to gain and maintain the relevant skills staff required to manage a range of obstetric emergencies. These included:

Maternity (inpatient services)

new-born basic life support, breech delivery (a breech birth occurs when a baby is born bottom first instead of head first), shoulder dystocia (where labour is obstructed by the infant's shoulder and manipulation is required), perineal repair (during delivery the perineum can tear) and sepsis. We saw the training programme included staff from other disciplines to promote multi-disciplinary learning.

- The trust set a target of 90% for skills and drills training. From April 2017 to March 2018, midwifery staff at bands 5,6,7 and 8 exceeded the trust target achieving 96.5% compliance. However, training compliance rates for band 2,3 4 staff and medical staff were below the trust target at 83.7% and 83.4% respectively. Service leaders monitored compliance rates regularly and managers were informed when staff did not attend this training. Minutes from local team meetings evidenced leaders had notified staff of their responsibility of ensuring they were up-to-date with this training.
- Community staff could access skill and drills training. However, these were orientated to the acute hospital setting and community staff told us they would benefit from community-based training which was better tailored to their needs.
- PREVENT training was below the trust target of 90%. As of June 2018, on the antenatal and post-natal wards maternity staff compliance rates were 100% for PREVENT 1 and 2 training and 50% for PREVENT level 3 training. The trust had implemented an e-learning training option in an attempt to improve PREVENT training compliance rates.
- Staff conducted sepsis training during their annual training day and skills and drills training. Staff were aware of the bacterial sepsis in pregnancy and the puerperium guideline which they could access on the trust intranet.

Safeguarding

- Staff understood how to raise patient safety concerns and were aware of the trust's safeguarding policy. The service regularly co-ordinated with other agencies to raise any patient safeguarding concerns and to ensure appropriate measures were put in place to protect patients from abuse.
- During the last 12 months, the maternity department had received the following safeguarding referrals: 150

referrals received for unborn children, 141 received from community midwives, five referrals received from acute (other), two were received from accident and emergency and two were received from health visitors.

- A dedicated named safeguarding midwife supported staff with safeguarding concerns; they did not carry their own caseload. Staff told us they could easily contact them for advice if required. We also saw safeguarding incident reporting guidance displayed in the staff room next to the clinical areas.
- Staff could also obtain safeguarding support from senior leaders of the service. A midwife described an occasion where staff had safeguarding concerns during a night shift and a senior leader attended the unit in person to support them.
- At our previous inspection, we found not all staff had completed the required safeguarding training. We were concerned patients were not protected from harm and this formed part of the warning notice we issued to the trust in September 2017. However, for this inspection we saw staff safeguarding training compliance had significantly improved.
- As of 30 May 2018, midwives and support staff and medical staff safeguarding training compliance exceeded the trust target of 90% for all levels of adult and children's safeguarding they were required to conduct. Training compliance rates for midwives and support staff as of 30 May 2018, was 100% for safeguarding children level one and level two training and 93% for children's level three safeguarding training. Compliance rates for safeguarding adults level one training was 100%, for level two and three adults safeguarding training was 96%.
- As of 30 May 2018, training compliance rates for consultants was 100% for both safeguarding adults level three and level three safeguarding children training.
- Female genital mutilation (FGM training) was included in the trust induction programme for new staff. Staff completed an online FGM course and were also provided with a booklet on FGM. The named safeguarding midwife delivered regular FGM updates to staff each year as part of safeguarding training. The service had a clinical lead for FGM for medical staff who was a consultant obstetrician and gynaecologist with a special interest in urogynaecology.

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- The service had appropriate support systems in place for vulnerable patients. The Women Requiring Extra Nurturing (WREN) team supported vulnerable women for their routine care. This team provided continuity for vulnerable families. The trust's safeguarding team provided supervision to staff who dealt with the most vulnerable patients such as the WREN team and community midwives. These staff also attended a specialised two-day training session. The safeguarding team staffed an advice line seven days a week and maintained a database of vulnerable women.
- At the time of booking, midwives asked patients a series of risk assessment based questions on mental health concerns, substance misuse, domestic abuse and Female Genital Mutilation (FGM).
- The maternity service had appropriate arrangements in place to safeguard women at risk of FGM. A suite of FGM questions included all mandatory reporting questions and discussions with patients about additional females in the household, whether temporary or permanent. If patients gave positive answers, staff generated an FGM alert and this was recorded on the maternity electronic records system. This added an FGM flag to the patient record so all trust staff were aware of patients at risk of, or had been a victim of FGM. Staff referred patients at risk of domestic abuse to a counselling service managed by an external provider.
- Maternity staff were aware of the female genital mutilation (FGM) policy, which was currently under review. Records we checked showed staff had documented safeguarding concerns in a patient's care notes and on the electronic reporting system. Staff told us if they had concerns relating to FGM they would inform the safeguarding lead midwife to report to the Department of Health (DH) in accordance with national guidance and legislation. The same process applied to child sexual exploitation concerns.
- We saw the trust had produced an FGM factsheet for professionals which included advice on what to do if staff have concerns a female under 18 years of age was either at risk or staff suspected may have had FGM. This included advice regarding reporting FGM concerns to Walsall Children's Service or the Police Child Protection Team and the local Safeguarding Children's Team.
- The maternity department had clear FGM reporting and information sharing arrangements with other agencies. The FGM alert triggered a referral to the Multi-Agency Safeguarding Hub (MASH) team for the patient and any other females at risk as identified from the process. The MASH investigation included any unborn female and female relatives in the household. The service had one referral in relation to FGM in a child over the last 12 months, and 30 regarding adults.
- A consultant held a weekly clinic for pregnant women who had experienced female genital mutilation. The service planned care for patients who had experienced female genital mutilation and signposted them to a FGM support group where patients could access a counsellor. An FGM health passport was provided to all relevant patients. This was available in several different languages. This outlined what FGM is, the legislation and penalties involved and the help and support available.
- The service had systems in place to check whether families were subject to a child protection plan. Staff asked patients at their first booking appointment if there had been any involvement in child protection.
- The safeguarding lead attended the unborn network meeting each month with the safeguarding board for Dudley and Walsall, senior nurse and social worker, teenage pregnancy team, mental health team, and health visitor. The safeguarding health visitor attended the monthly network meeting to provide a link between the MASH team and the trust. Safeguarding issues relating to vulnerable women were discussed. Actions were identified and allocated to a practitioner who took responsibility for their actions. Minutes were circulated in a timely way to ensure all relevant staff were aware of concerns.
- The named safeguarding midwife provided training for the local safeguarding board regarding child protection processes. The service also planned to implement a multi-agency training day with the FGM support group leader. The safeguarding midwife attended multidisciplinary meetings with lead agencies to share good practice and information regarding safeguarding policy updates.

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- The service had a health visitor with responsibilities for asylum seekers, travellers and migrants to ensure they were supported. These patients were added to the unborn network database.
- There had been a recent Looked after Children's review. The final version of the report had not yet been released to the service, the safeguarding midwife was aware of the initial findings in the draft report and was currently reviewing the report.
- All babies wore an electronic safety tag whilst in the maternity department. Staff removed the tag before discharge. Staff were aware of their responsibilities during a possible abduction incident in line with the trust's abduction policy. However, there had not been any recent infant abduction exercises conducted in the department to check for any gaps in the process and assess staff awareness of their role.

Cleanliness, infection control and hygiene

- All areas of the maternity unit were visibly clean and clutter free. Equipment we checked was clean and had 'I am clean stickers' to confirm when they had last been cleaned. Staff managed waste appropriately and disposed of clinical specimens according to trust policies.
- The service had a system in place to ensure taps not in constant use were regularly flushed to prevent the spread of waterborne infections. The water pools on the delivery suite had a regular cleaning schedule, which was up-to-date, and showed staff cleaned pools before and following patient use. Community and delivery suite staff conducted pool evacuation training.
- Hand sanitising gel was fully stocked and positioned at each clinical area entrance for staff and patients to use. We saw staff cleansed their hands between each patient contact.
- Staff adhered to the maternity service uniform policy. We saw guidance regarding maternity staff uniform displayed in the staff room.
- We reviewed the service's monthly infection prevention and control (IPC) audit results for the delivery suite from April 2017 to April 2018. The trust had a target of 90% compliance. The results were Red, Amber, Green (RAG) rated according to compliance rates. Green was allocated to rates of 90% and above, amber was between 80 and 89% and red was below 79%. The trust target was green (met the target) for only one month

during this time period, achieving 94% compliance in January 2018. For the remainder of this time period; seven months were red rated and five months were amber rated.

- We saw an action plan to address poor compliance rates, which included ensuring staff were reminded of the five points for hand hygiene. However, this did not evidence who was responsible for each action and any target dates for completion. Compliance rates continued to be below the trust target and we were not assured the service effectively managed infection risk well and used control measures appropriately to prevent the spread of infection. Senior staff had not taken sufficient timely action to improve IPC compliance in the unit.
- Staff appropriately used personal protective equipment such as aprons and gloves. We saw these were readily available, which staff confirmed. Overall, staff were 'bare below the elbow' in accordance with the trust's infection prevention and control policy. However, we saw one staff member working on the delivery suite wearing nail varnish. We raised this with the staff member during the inspection who told us they would remove it as soon as possible.
- The maternity service had not reported any MRSA or C. difficile cases in the last 12 months. All patients were routinely screened for MRSA.

Environment and equipment

- The maternity unit had medical equipment in place in accordance with the Royal College of Obstetricians and Gynaecologists Safer Childbirth: 'Minimum Standards for the Organisation and Delivery of Care in Labour' recommendations. Community staff told us they had access to all the equipment they required.
- Staff checked adult and neonatal resuscitation equipment each day in all areas of the maternity department. This was in accordance with the trust's policy.
- All equipment conformed to the relevant safety standards and were up-to-date with electrical testing. A midwifery support worker had responsibility for maintaining equipment across the department.
- We reviewed the fire safety risk assessments for the department. We saw they did not accurately reflect some of the risks and did not take into account

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significant changes on the antenatal and postnatal wards. For example, the fire assessment stated no portable heaters were in use. However, we saw them on wards during our inspection. In addition, some fire doors were propped open with bins, which did not comply with fire safety regulations.

- Some of the environment on the maternity unit was tired with some damage present. For example, we saw some chairs had ripped areas particularly in the antenatal clinic waiting areas and damaged plaster and wallpaper in ward areas. This meant effective cleaning would not be possible to reduce infection risks.
- Some staff told us the maternity department could be very cold, especially during the winter months. Staff told us they had raised this as an incident, which prompted monitoring, but no further action had been taken.
- Cardiotocography (CTG) machines had 'I am clean' labels attached confirming staff had cleaned and checked them. The resuscitaires were visibly clean and tidy with all stock in date. Resuscitaires are devices used in maternity units which combine a warming therapy platform and components required for clinical emergencies and resuscitation.
- The delivery suite was located on the same floor and in close proximity to the obstetric theatres and neonatal unit should patients require transfer to these areas.
- Following our previous two inspections in 2015 and 2017, we highlighted the delivery suite only had one dedicated obstetric theatre and recovery area with the second theatre being unfit for purpose. The service monitored the number of times the second theatre had been opened on the maternity dashboard. From November 2017 to April 2017, the second theatre was opened on a total of five occasions. However, we saw the service was taking action to mitigate this concern during this inspection, as construction work had recently begun on building a second dedicated obstetric theatre for the delivery suite. All elective caesarean sections were conducted in the gynaecology theatre.
- The service had purchased some active birth beds to support normal birthing methods. However, staff told us they had not received specific training to use the beds for normal births and they were sometimes used in a standard way.
- The midwifery led unit (MLU) had been temporarily closed in July 2017 with activity and staffing relocated to the delivery suite within the acute setting. During this inspection, the MLU remained closed. However, we saw plans to use the MLU for some outpatient clinics.
- Visitors gained access to the delivery suite and the maternity wards via an intercom and buzzer system. This ensured patients were kept safe whilst on the unit. Staff had swipe card access to gain entry to the department. CCTV was in place at the entrance to each area of the department.
- During the inspection, we saw security was well managed on the delivery suite. Staff reported an individual was unaccompanied in the department and we saw staff took prompt action.
- Isolation rooms were available in the maternity unit should they be required for patients with infectious diseases.
- The service had two bereavement rooms with en-suite facilities. However, they were situated on the delivery suite main corridor which meant recently bereaved parents may come into contact with new-born babies.
- Senior service leaders were aware the lone worker policy did not effectively cover midwifery staff working alone in community. The revised policy was under development during our inspection and was due for release by the end of June 2018. This was recorded on the maternity risk register. However, to help mitigate this risk, the service had provided community midwives with a mobile phone to ensure they were kept safe. Community midwives sent a text message to senior staff to inform them they were safe when working alone. Senior staff would check on their welfare if this message was not received.
- During our last inspection, we highlighted there were insufficient breast pumps for use in the department as there were three breast pumps for patients to use to help breastfeed their babies. We saw breast pump provision had now improved with two available on the postnatal ward, the neonatal unit had eight breast pumps and three were available to loan. The Health in Pregnancy team also arranged breast pump loans to women who required this support.

Assessing and responding to patient risk

- The service had a birth cap of 4,200 per year in place. This was implemented in March 2016 following

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discussions between leaders of the maternity service and stakeholders to address shortfalls in staffing numbers and increased demand for services. Service leaders and stakeholders regularly reviewed the birth cap. There was some pressure from the local maternity system (LMS) to remove the cap. Senior leaders and maternity staff were concerned increasing deliveries up to 5000 births at the trust would put a strain on the service.

- A neighbouring trust took 500 women to birth at their trust to relieve pressures on the maternity unit.
- Staff used the sepsis six bundle to assess women in maternity. In records we reviewed staff had appropriately used this pathway. Maternity staff we spoke with were knowledgeable about sepsis and how to escalate women with deteriorating conditions. Staff understood how to access the sepsis guideline on the trust's intranet.
- Maternity staff completed modified early warning score (MEWS) to assess if a patient's condition was at risk of deterioration. The service had a Maternity Early Warning Scoring guidance for staff. This was due for review in October 2017 and was currently being reviewed.
- We checked five MEWS charts and saw staff had fully completed them and appropriate actions taken. Senior staff monitored staff compliance to MEWS on the maternity inpatient wards each week. This included reviewing 10 patient records from 10 different patients. Between October 2017 and May 2018, the average result was 98%, which was above the 90% target. In response to a poor compliance rate of 70% in week four of May 2018, an action plan had been implemented to address this result. This included managers discussing non-compliance with individuals concerned and raising staff awareness at team meetings. This audit was not routinely conducted on the delivery suite however, we were told this was planned to be implemented in future. We reviewed the chart used to conduct this audit and noted there was a discrepancy between the chart and the weekly data we received as the chart stated for the audit to be conducted monthly.
- Staff used the World Health Organisation (WHO) surgical safety 'Five Steps to Safer Surgery' checklist in the

maternity theatre. Audit results from May 2017 to April 2018 showed staff used the checklist appropriately as compliance was consistently 100% for each month with the exception of May 2017 which scored 97%.

- During our last inspection, we had concerns maternity staff did not monitor, record and escalate concerns regarding cardiotocography (CTG) reviews to protect women and their babies from abuse and avoidable harm. This formed part of the warning notice we issued to the trust in September 2017. A CTG measures babies' heart rates and monitors the contractions in the uterus. Staff used a CTG before birth and during labour, to monitor the baby for any signs of distress. Following our last inspection in June 2017, we requested the service send us weekly data to include staff CTG compliance.
- The service conducted weekly audits of 10 sets of CTG records to monitor staff compliance. When we first began to receive weekly data for the week commencing 14 August 2017, CTG documentation was poor. For example, of the 10 records that had been checked for that week, 10% (1 record) had fetal heart recorded and 44% had hourly fresh eyes recorded.
- To improve CTG monitoring, team leaders implemented spot checks of CTGs as a result to ensure staff had completed fresh eye checks. The service had also added an additional final CTG peer review check post-delivery. From 18 December 2017, a colleague peer review of all CTGs at the point of delivery was added to the checks. This was to ensure the whole team were engaged in the review of the standards required and had achieving the 100 % target in all of the CTG audit domains as a priority. Where staff were non-compliant, an additional governance process had been implemented in consultation with the trust's human resources team for staff who were persistently highlighted in the audit as non-complaint. This process would take the staff member through a process of assessment of capability and further training and support if required. Disciplinary action would be taken if necessary. To commend good practice on the unit, the service leaders also highlighted when staff consistently met the standard of audit requirements.
- During this inspection, we reviewed 10 cardiotocography (CTG) paper traces. Staff had fully

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completed all CTG documentation we checked including hourly reviews on all CTGs we checked where this was required. This was a significant improvement from the previous inspection.

- The continuing professional development midwife had produced CTG stickers and prompt sheets to improve CTG monitoring compliance. They also led training events including the use of pinards (a type of stethoscope used to listen the heart rate of a fetus during pregnancy).
- We observed a multidisciplinary CTG review was undertaken following a handover where staff were requested to interpret the findings. This was used as an opportunity to share learning and good practice as a retrospective review. An anaesthetist formed part of the review to provide additional information regarding anaesthetic care. The service now consistently held weekly CTG meetings to review actual CTG recordings. This was used to review decisions made and determine how this had affected subsequent emergency caesarean sections. This review promoted learning and was a supportive meeting for staff and did not proportion blame.
- Staff completed patient risk assessments to aid them to choose their preferred place of delivery, recommend further investigations and provide them with an individualised care plan. This included whether a patient was recommended for midwifery or consultant-led care and if referrals to other professionals in the multidisciplinary team were required. Patient's needs were assessed at triage on arrival to the maternity unit. Records we checked demonstrated community staff had conducted full risk assessments of patients at their first booking visit. These included documenting a patients' social history.
- Midwives staffed the triage area 24 hours a day, seven days a week. Patients were transferred either to the delivery suite or back to their home if they were not in the later stages of established labour. Staff reported any babies born before arrival (BBA) via the trust's electronic incident reporting system. The service would conduct an investigation and lessons learned and shared.
- The trust set a target of 95% for staff completion of VTE assessments. This was documented on the maternity dashboard. From November 2017 to April 2018, the VTE

assessment compliance rates had significantly improved across all areas of the maternity service since our last inspection. This meant patients were appropriately assessed for their risks of developing deep vein thrombosis. The antenatal ward results were above the trust target for five of the six months at 100% for each month, with the sixth month just below the trust target in March 2018 at 94.74%. From November 2017 to April 2018, the VTE assessment results for the postnatal ward were above the trust target for five of the six months, achieving 100% for three of the five months. In November 2017, compliance was below the trust target at 92.24%. In contrast, from November 2017 to April 2018, VTE assessments conducted on the delivery suite were just below the trust target for five of the six months with an average of 93.36%. The trust target was met in March 2018 at 96.79%. VTE prophylaxis was indicated in all eight of the 20 prescription charts, which required this assessment.

- Maternity staff discussed the importance of monitoring fetal movement at their antenatal appointments in accordance with MBRRACE-UK 2015 and RCOG guidance. Posters were also displayed and leaflets were available in the antenatal clinic.
- During our previous inspection, we had identified responses to the escalation process had been insufficient. The service had fully revised the maternity unit staffing and escalation policy following our 2017 inspection to ensure it supported the safe provision of maternity services during times of high acuity and/or staffing shortages. The policy confirmed the arrangements for assuring safe staffing levels for all midwifery, nursing and support staff were in accordance with Safer Childbirth, RCOG 2007 recommendations and Safe Midwifery staffing for maternity services (NICE 2015). The policy also provided guidance on the actions to take if the maternity unit was at full capacity.
- An account of each time the escalation policy was initiated in response to the acuity tool formed part of the weekly information we requested from the trust in July 2017. This was to enable the service to monitor themes for escalation policy instigation. The service collated this information each day as part of the safety huddle review. For example, for the week commencing 4 December 2017, the escalation policy had been initiated six times due to high activity and staffing shortfalls on

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the Friday and at the weekend as staff were unable to get into work. The service provided assurance patient safety was maintained despite the pressures the department was experiencing.

- The service had an up-to-date guideline for bacterial in pregnancy and the puerperium. This included based on NICE and RCOG recommendations.
- Staff monitored fetal growth from 24 weeks by measuring and recording the symphysis-fundal height (measured from the top of the mother's uterus to the top of the mother's pubic bone) at each antenatal appointment. This was in accordance with MBRRACE-UK 2015 and NICE CG62 guidance. If staff had concerns regarding fetal growth they would refer the patient for a full assessment. This process was detailed in the maternity service's guideline for the management of small for gestational age fetus.
- The department monitored the proportion of booking appointments, which took place before 12 weeks of pregnancy. From May 2017 to April 2018, 88.43% of appointments had taken place, which was just below the 90% target. However, following discussions with clinicians, senior staff were confident women were booked in for appointments in the correct time period. The service believed this result was due to data quality input issues and needed to conduct further investigations regarding data collection to validate this.
- The service monitored the number of term admissions to the neonatal unit (NNU) (planned and unplanned). From April 2017 to March 2018, there had been 163 admissions. The number of term and term avoidable admissions to the NNU had recently been added to the maternity dashboard. In line with NHSI CAS alert in 2017, all term admissions dating back from January 2018 were being reviewed by a multi-disciplinary team of midwives, obstetricians and neonatologist for learning.
- Staff told us if they had concerns regarding a patient's mental health they could contact the perinatal mental health team or trust's mental health team for support.

Midwifery and Nurse staffing

- Insufficient numbers of suitably qualified staff on the delivery suite and maternity wards formed part of our enforcement action taken against the trust in September 2017. The service evidenced significant

improvements in staffing levels across the department. Staffing levels were sufficient for the current birth rate, however, there may not be enough staff if the department was delivering to its capped level and if the midwifery led unit re-opened for women to give birth there.

- Maternity staff confirmed staffing levels had improved since the last CQC inspection and the department was a calmer, more supportive environment.
- Before the last inspection, staff shortfalls in staffing levels were a regular occurrence but the majority of shifts were now filled. However, staff were not always able to take their breaks. Senior staff had encouraged staff to incident report when they had missed breaks but staff stated the incident reporting system was too complex and time-consuming and this was often not possible.
- A Birthrate Plus assessment had been carried out in the department. Birthrate Plus is a workforce-planning tool used in maternity units. This had calculated that the department was understaffed by 7.5 whole time equivalent staff for the 4,200 birth cap. However, staffing was sufficient for the current birth levels which were below the cap. The department had a rolling recruitment programme in place to increase the staffing establishment.
- The midwife to birth ratio was recorded on the maternity dashboard. From May 2017 to June 2018, the midwife to birth ratio met the national target of one midwife to 28 births for eight months. The average for the eight months was 1.25.7. For the remaining four months, the midwife to birth ratio was 1.30.5 in May 2017, 1:29.2 in August 2017, 1:28.1 in September 2017 and 1:29.8 in April 2018, with the average across the four months of 1.29.4.
- We reviewed the methodology service leaders used to calculate Birthrate Plus calculations. They did not include non-clinical staff in the calculations in accordance with the Birthrate Plus guidance. This showed they had the funded establishment for current birth levels and robust contingencies for covering sickness and maternity leave with bank staff. We

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checked the data for May 2018 as an example. For the funded establishment for 3672 births this would give the service a midwife to birth ratio of 1:27 for May 2018 which was better than the national target.

- The trust monitored the percentage of episodes when the delivery suite was appropriately staffed using an acuity tool. During the period November 2017 to April 2018 the trust achieved its target of 85% for four of those months, December 2017, 85% January 2018, 89%, February 2018, 92% and March 2018, 88%.
- A team leader was available for each shift on the delivery suite in line with best practice. Night staff were required to contact the delivery suite manager to provide an update regarding staffing, even if staffing was up to establishment.
- At our last inspection, students told us they were regularly providing one-to-one care to patients in established labour. Student roles should be supernumerary and this did not comply with NMC guidelines. During this inspection, student midwives confirmed they were always supervised when providing one-to-one care. Staff told us, they provided one-to-one care more regularly now and the service monitored this closely and recorded it on the monthly maternity dashboard. From June 2017 to May 2018 the service achieved their 100% target for one month, May 2018 in line with NICE NG4 guidance: Safe Midwifery Staffing. However, from June 2017 to April 2018, the percentage of patients receiving one-to-one care was just below the trust target for each of these months with a range between 93.62% and 99.98%. The trend over time showed a significant dip in August 2017 (93.62%) with gradual and sustained improvement across the following months, with figures around the 99% mark.
- The sickness rate in maternity at the end of March 2017 was 5%, which was higher than the trust target of 3.39%. From November 2017 to April 2018, the sickness rate on the antenatal and postnatal wards was above the trust target for every month. In November 2017, the sickness rate was 9.86%, December 2017 12.87%, January 2018 9.32%, February 2018 3.97%, March 2018 4.13% and April 2018 6.26%. During the same period sickness rates on the delivery suite was 8.65% in December 2017, 7.05% in January 2018, 6.21% in February 2018, 3.24% in March 2018 2.92% and April 2018 was 3.02%. This showed on the antenatal and postnatal wards, sickness levels remained significantly higher than the trust target, however the sickness levels on the delivery suite reduced and were below the trust target from February 2018 to April 2018.
- During our inspection, actual staffing levels on the ward and delivery suite met planned staffing levels. We reviewed staffing levels from November 2017 to April 2018. The actual staffing versus establishment during the period November 2017 to April 2018 was below the target of 100%. In November 2017, it was 91%, December 2017 it was 90%, January 2018 was 82%, February 2018 was 82%, March 2018 was 85% and this was not recorded on the dashboard for April 2018.
- The department mainly used bank staff to cover unfilled shifts however, agency staff were occasionally used. The service used a text message alert system to inform staff when bank shifts were available. The highest bank usage was on the Foxglove ward and the delivery suite. The highest agency usage was on the Foxglove ward.
- Some staff worked 12-hour shifts. Staff feedback regarding flexibility of hours was mixed. Some staff were able to work quite flexible hours if requested however, other staff told us if personal circumstances changed and they requested to work reduced hours, service leaders did not consider the change in working pattern.
- Community midwives had previously held an average caseload of one midwife to between 60 and 100 women depending on the needs of the women. This was in line with the national recommendation of one midwife to 100 women. Leaders of community maternity services told us caseloads had been reduced and there was now a better distribution of caseloads. The community structure had been amended to have eight smaller teams rather than the previous four team structure.
- A recruitment event was held in February 2018. The service offered 12 midwives positions at the trust as a result and all of these staff still remained in post. Some midwives from other trusts had also joined the service, which improved the staffing mix of long standing staff and recently recruited and qualified midwives. We were told a member of staff had recently left and they had requested to return to work in the maternity department.
- The recent recruitment of staff had increased band 7 posts in the department. The service aimed to have two

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team leaders on each shift. One team leader would be acting as team leader and the other would be responsible for providing senior clinical leadership and support.

- Since our last inspection, service leaders had implemented a safety huddle. This was held three times a day to review staffing levels and skill mix across the maternity unit and to deploy staff to where they were most needed.
- We attended a handover, which we saw followed a Situation Background Assessment Review (SBAR) format and was held away from patient areas. SBAR is a technique that can be used to facilitate prompt and appropriate communication. This was well attended by a range of multidisciplinary staff including consultant obstetricians, consultant anaesthetists, midwives and registrars. We saw staff discussed all appropriate information.

Medical staffing

- The maternity service had sufficient access and support from medical staff 24 hours a day, seven days a week.
- The service had 16 obstetrician/gynaecology consultants in post.
- Between November 2017 and March 2018, the trust had 142.5 hours of timetabled obstetric consultant cover on the labour ward per week for every month. This exceeded the 'Safer Childbirth/RCOG: The Future Workforce' recommendation and was above the national target of 98 hours. The maternity dashboard did not document the April 2018 figures.
- Consultant staffing was dependant on locum consultant cover, particularly at night and to cover the on-call rota. Senior staff stated they needed more substantive consultants to provide more stability to the consultant workforce.
- Some medical staff reported a two-tier hierarchy of consultants with some consultants believing established consultants conducted the "important jobs" with locum consultants covering the elective caesareans section lists and the remaining procedures.
- Staff told us they had seen improvements in accessibility of medical staff on the delivery suite since the last inspection. Consultants conducted the ward rounds regularly and they now all took responsibility.

We saw and staff confirmed there was regular consultant presence on the wards and in the delivery suite. Junior staff confirmed they felt well supported by consultants.

- The delivery suite had anaesthetic cover for 24 hours a day, seven days a week. Anaesthetic cover was available on site for 50 hours per week with on-call cover out-of-hours. From November 2017 to March 2018, the anaesthetic consultant hours cover on the delivery suite met the national target of 50 hours every month. The maternity dashboard did not document the April 2018 figures.
- Staff told us there had been improvements in the medical staffing cover of the fetal assessment unit. This had taken the pressure off the delivery suite.
- From November 2017 to April 2018, there were no sickness absences for consultants. This was therefore below the trust target of 3.39% for each month. However, from November 2017 to April 2018, sickness rates for antenatal clinic staff were above the trust target for all six months, with the highest sickness rate in April 2018 at 7.90%. Sickness levels on the antenatal and postnatal wards were above the trust target for each of the six months with the highest sickness rate in December 2017 at 12.87%. On the delivery suite, sickness rates were above the trust target for three of the six months with the highest sickness levels in November 2017 at 8.65%.

Records

- The service used an electronic maternity records system together with paper-based patient records.
- We saw patient's medical records were securely stored in lockable trollies across the department. This was an improvement from our previous inspection where we found a key remained in the lock of one of the records trollies.
- We reviewed 17 sets of maternity patient records. All records were clear to navigate and contemporaneously completed. This was an improvement from our previous inspection. We saw records accurately recorded patient's choice. They also evidenced staff had held multidisciplinary discussions to ensure patients received patient-centred care as described in their care plans. Referrals to specialist services were clearly noted.

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- Theatre notes we reviewed showed staff had fully completed theatre care plans.
- Antenatal patient records were paper based as well as recorded on the electronic system. Midwives gave patients their patient records and requested they bring them to each antenatal appointment.
- We highlighted in our previous report the service did not conduct general documentation audits we and we were not assured all the other assessments were being used as intended. We saw records audits and information inputted onto the maternity electronic system were included on the clinical audit forward plan for 2018 – 2019.
- Risk assessments were clearly documented and completed in all the records we reviewed.
- The service provided mothers with a 'red book' before they were discharged home. This was a personal child health record to document the child's health and development.
- Patient's discharge plans were communicated to their GP and community teams where appropriate, via a letter on discharge from the maternity unit. This communication had been promptly sent in the records we reviewed. The service did not currently audit appropriate completion of discharge information on the patient records system. However, the patient care improvement plan included providing refresher training for all users of the maternity electronic system to include an on-going maternity documentation audit plan.
- When appropriate, records included specialist patient needs such as mental health and learning disability needs together with their physical needs.
- Staff could seek advice from the trust's mental health team if a patient attempted to discharge themselves, refused treatment, or had other additional mental health needs.
- The maternity service ensured all relevant staff were updated when a patient had experienced pregnancy loss.
- Overall, fridge temperature checks were within required limits. However, in the clean utility on the wards we saw the fridge temperatures exceeded maximum levels for five days in June 2018. The temperature monitoring form stated staff should escalate to the Nurse in Charge when the temperature exceeded this level. However, we saw no evidence that this action had taken place. This meant some medication may have been stored above their safe temperature storage limits.
- Staff had conducted daily room temperature checks as required. This ensured medication was stored in the safe temperature range.
- The service conducted medicines audits to check medication was stored appropriately across the service. Service leaders conducted ward storage assurance spot checks of 10 key medicines storage standards each week. From April 2017 to March 2018, the average compliance rates for each area of maternity exceeded the 90% target. Ward 24 compliance was 99%, ward 25 was 98.5% and the delivery suite was 98%.
- Service leaders also carried out controlled drugs (CD) audits, one annual CD audit of 31 key standards and three quarterly audits of eight key standards. Overall average percentage compliance from April 2017 to March 2018 was above the trust target at 97% on ward 24. However, compliance was just below the trust target at 83% on ward 25 and there were poor compliance rates on the delivery suite at 63%.
- In response to identified areas of non-compliance in the CD audit, the trust's medication safety officer delivered a presentation on CD management in monthly maternity clinical updates. This highlighted medication concerns that required addressing and case scenarios to discuss appropriate actions regarding CD management. The areas of non-compliance related to stock and balance checks in the CD record books including the trust standard documentation relating to amendments made in the CD stock booklet. Pharmacy staff also arranged meetings with the matrons of areas where CD audit standards required improvement, such as the delivery suite. This was to discuss an action plan to address non-compliant standards.
- Staff had conducted daily checks for controlled drugs across the maternity service in accordance with the trust's medicines policy.
- Medical gases were appropriately stored in a ventilated room. However, on the antenatal and postnatal wards,

Medicines

- The service managed and disposed of medication and controlled drugs safely and in line with the trust's medication guidance.

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gases were stored without the required signage on the doors. We raised this to the senior management team during the inspection. When we returned for our further inspection visit on 12 June 2018, we saw the service had addressed this in a timely way as temporary signs were in place whilst permanent signage was being processed.

- We reviewed 20 prescription charts for maternity and found 18 out of the 20 records were signed and dated. In the previous inspection we highlighted illegible entries was an issue. This had improved for the records we checked for this inspection, as all entries were legible. We saw all 20 records had allergies recorded which was an improvement from the last inspection where three of the 12 charts checked did not have allergies recorded. We saw patients with allergies wore red wristbands detailing their allergies to ensure all staff were aware.
- The service was planning to introduce patient self-medication to promote self-care for patients. A policy had been agreed and lockers for safe storage of medication were on order.

Incidents

- Staff recognised incidents and understood how to report them on the trust's incident reporting system. Staff felt confident to raise incidents and were not concerned about a 'blame culture.' This was an improvement from our previous inspection.
- Managers investigated incidents quickly and shared lessons learned and changes in practice with staff. When things went wrong, staff apologised and provided patients with suitable support and information. Since our last inspection, we found learning from incidents had improved. Staff were able to provide examples of maternity incidents and evidence of change of practice implemented in a timely way in response. However, some staff said learning from incidents was not always shared with all relevant staff.
- Staff told us learning from incidents was collectively discussed at team meetings. Team meeting minutes confirmed this.
- From June 2017 to June 2018, the trust reported two never events for maternity. This was an increase from the previous year as no never events occurred from June 2016 to June 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how

to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. We reviewed the root cause analysis reports for each never event.

- The first never event in July 2017 related to a medication error. This involved the administration of epidural medication into an intravenous port instead of the epidural port. The root causes identified were: lack of physical barrier(s) to prevent the connection of an epidural into the wrong port, failure to follow trust guidelines and policies for the establishment and management of epidural analgesia in labour, and human error. The action plan relating to this never event was tested in January 2018 by the trust and Walsall clinical commissioning group. This test showed that staff understood the epidural drug administration processes and they had self-certified that they were competent, and they knew how epidural block height was assessed. It was also found that further work was required for training staff who had been out of practice for some time, and that clear direction was required for how often observations of the epidural should be undertaken. In order to prevent reoccurrence, the service implemented the use of yellow stickers to identify the correct epidural ports to use. The service was also in the process of purchasing equipment where the different ports were colour coded accordingly. The practice delivery midwife included sessions on the clinical update to include epidural training.
- A second never event was in relation to a retained swab during a perineal repair. The investigation panel considered there was a lack of clarity of roles and responsibilities before and following the procedure for perineal trauma regarding the counting and documentation of swabs, needles and instruments. We saw the associated action plan listed identified areas of improvement required which included updating guidelines and policies in relation to invasive procedures where the counting of swabs, needles and instruments was required. Hospital based and community staff were aware of changes in response to this never event which included using new larger swabs which were more difficult to leave behind.
- The trust reported four maternity serious incidents in the last 12 months in accordance with the Serious

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Incident Framework, 2015 reporting criteria set by NHS England. We reviewed the serious incident investigation reports. The serious incident reported in March 2018 was initially reported as a never event which relating to a wrong site surgery. A consultant gynaecologist from another trust was appointed to conduct an independent root cause analysis (RCA) review to enable the investigation to be fully transparent. However, the RCA investigation stated this did not fall into the category of never event for wrong site surgery. The trust did not down grade this to a serious incident as wished to retain the never event incident level to adequately recognise and address the process and system errors which had been identified for this incident to occur. We saw immediate actions had taken place to prevent reoccurrence and learning was shared across the department and throughout the whole trust. The root cause of this incident was agreed to be directly as a result of operator error due to a failure to fully review the appropriate patient area before removal. A communication breakdown between the surgeons regarding clarity of responsibilities and seniority of the roles and the communication between the surgeons about the actions being taken was not sufficient was also identified as a root cause. The associated action plan documented areas for improvement in response to this incident. This included reviewing the guideline for the management of ectopic pregnancy in line with the latest national guidance.

- One of the serious incidents related to an intrauterine death that occurred in April 2018. This was currently under investigation and the department had reviewed this incident using the serious incident framework.
- The incident review process had improved from our last inspection however, the RCA process was still not sufficiently robust and further improvement was required. Staff felt the main root cause was very often missed during the analysis process and RCAs usually identified process issues but not competency issues. We were told of a recent example where all relevant information was not available for review at the table-top session. Staff told us feedback from incident investigations was not always shared with staff and action plans were not always circulated to all appropriate staff.
- Learning events were held where there had been adverse outcomes. Senior staff gave the most recent never event as an example. Multidisciplinary discussions took place to discuss incidents which staff told us was a recent improvement.
- Feedback mechanisms for sharing information about incidents with staff had improved. We saw senior staff provided feedback regarding incidents at handovers and the governance team shared incident information via a risk newsletter. Service leaders also discussed incidents with staff at handovers.
- Between May 2017 and April 2018 there were a total of 119 reported clinical incidents categorised as no harm or low harm in maternity services.
- Between May 2017 and April 2018, the service had 13 stillbirths and 10 perinatal deaths. The service held monthly multidisciplinary perinatal mortality and morbidity meetings, which fed into service improvement. We reviewed six sets of minutes, which confirmed a multidisciplinary team discussed outcomes and learning and recommendations were made.
- Staff incident reported staffing shortages. This enabled the senior maternity team to have oversight of staffing shortfalls.
- The service demonstrated how they met the Duty of Candour regulation. The Duty of Candour is a regulatory duty that relates to openness and transparency. The trust was aware of its role in relation to the Duty of Candour regulation introduced in November 2014. It requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. This defines specific requirements providers must follow, which includes an apology given to patients by the trust.
- Staff demonstrated a good knowledge of the Duty of Candour. The trust sent an initial apology in writing and communication when the review of the case has been completed. The service also provided a copy of the investigation report to the patient and offered a meeting to discuss the findings.
- We reviewed five letters to patients apologising for the experiences and shortfalls in maternity. Four out of the

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five of the letters offered face-to-face meetings if required. We reviewed investigation reports and saw families were not always involved or had the offer to become involved in incidents.

- The service was beginning a pilot for a Duty of Candour (DoC) leaflet to be used in maternity. This described the DoC process and included space to record the key aspects of the discussion and who the patient/relative could contact. There was also a tear off strip for inclusion in the health record. The aim was to reduce some of the paperwork whilst still complying with the duty and to enable staff to enact the duty as quickly as possible.
- Divisional huddles were held each week to discuss outstanding concerns. Senior maternity staff and the governance team assessed feedback provided to incidents. This had not been well attended by clinicians where clinical engagement with governance remained an issue. However, engagement had improved over the last few months. Weekly divisional huddle meetings were held. Incidents which were considered to be a serious incident were taken forward to the weekly serious incident meeting for discussion.

Maternity Safety thermometer/Maternity Dashboard

- The maternity service submitted data to the maternity safety thermometer each month. This is a national tool, designed to measure commonly occurring harms within maternity care. Data was collected on a single day each month to indicate performance in key safety areas. These areas included perineal (area between the vagina and anus) and/or abdominal trauma, post-partum bleeding, infection, separation from baby and women's perception of safety. The service recorded this each month on the maternity dashboard.
- From May 2017 to April 2018, women's perception of safety improved from 64.3% in November 2017 to 100% in April 2018. The proportion of women who reported they had concerns about safety during labour and birth that were not taken seriously reduced over time from 35.7% in November 2017 to 0% in April 2018. The proportion of women that had a maternal infection since the onset of labour or within 10 days of birth was mixed scoring 0% for three of the 12 months and scoring over 17% for two months; August 2017 and March 2018.

- The maternity thermometer was clearly displayed on a noticeboard in the main delivery suite corridor. We saw this was an improvement from our previous inspection where we found the graph was too small to read the information.
- The maternity safety thermometer was regularly discussed at the maternity inpatient forum.
- The maternity service maintained a local maternity performance dashboard, which reported on activity and clinical outcomes. The dashboard indicated where there was monitoring against local or national targets to allow the service to benchmark the service's performance.

Are Maternity (inpatient services) effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Fridges to store breast milk were unsecured during our inspection which had been a concern at our previous inspection. The service addressed this in a timely way however, there was not a process in place to ensure these fridges remained locked.
- Breastfeeding support provision for patients was currently insufficient. The service had implemented plans to fill this shortfall in breastfeeding support provision whilst more permanent support was being sourced.
- The service did not meet the target for initiation of breastfeeding within 48 hours for nine months from April 2017 to March 2018.
- The guideline reviewing process had improved since our last inspection however, there was still further scope for improvement.
- The service did not currently audit the median time from patients requesting an epidural to receiving one or the number of women given an induction who were given appropriate pain relief in accordance with NICE guidance, CG70, July 2008.
- The service audited post-natal re-admissions however, the associated action plan did not appear to clearly identify improvements.

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- Community staff no longer carried out home bookings which meant patients had to attend clinics and there was no availability for weekend appointments.
- The service did not always ensure vaccination provision was sufficient to protect women and their babies.

However;

- The maternity service benchmarked their maternity service provision against the NHS England National Maternity Better Births Review, February 2016.
- Staff appropriately assessed patient's nutrition and hydration needs.
- Evidence based care was evidenced from 24 weeks in relation to fetal growth monitoring in the records we checked.
- Multidisciplinary communication had improved from our last inspection however, further improvement was required as anaesthetists were not always involved in HDU ward rounds and supporting more junior colleagues in maternity.
- The service had sufficient HDU staff on each shift which was an improvement from our last inspection.
- The service had reduced the average combined elective and emergency caesarean section rate since the last inspection.
- Staff appropriately assessed, managed and administered patient pain relief. The delivery suite had anaesthetic cover for 24 hours a day, seven days a week.
- As of June 2018, the service had no active maternity outliers.
- All necessary staff, including those from different teams were involved in assessing, planning and delivering care and treatment to patients.
- There had been an increase in the amount of opportunities for hospital based and community staff development which had been a concern in the past. The service had secured funding for 170 midwives to conduct Phi strategic leadership programme training.
- Staff were knowledgeable about the basic principles of consent and Mental Capacity Act 2005. We saw staff appropriately gained patient consent for treatment in accordance with legislation and guidance. Records we checked confirmed this.
- All staff groups showed an improvement in appraisal rates from January 2018. The largest improvement was seen for medical staff.
- Leaders of the service identified and managed poor or variable staff performance.

Evidence-based care and treatment

- The maternity service was managed in accordance with NICE guidelines and quality standards. The Divisional Director of Midwifery, Gynaecology & Sexual Health promoted adherence to national standards across the department.
- The maternity service took part in national benchmarking clinical audits such as the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit) of UK Perinatal Deaths.
- All actions to reduce morbidity and mortality levels of the service in response to MBRRACE results were fed into the saving babies lives care bundle and Clinical Negligence Scheme for Trusts (CNST) incentive scheme.
- The maternity service benchmarked their maternity service provision against the NHS England National Maternity Better Births Review, February 2016. The review was to assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies. Compliance was monitored as part of the maternity improvement action plan.
- Evidence based care was evidenced from 24 weeks in relation to fetal growth monitoring in the records we checked.
- At our previous inspection, we reviewed 17 guidelines of which 11 were out-of-date. During this inspection, we saw the guideline reviewing process had improved as the service had updated the majority of guidelines. As of July 2018, there were no policies out of date; one policy was awaiting ratification and seven were under review. Regular group guideline meetings were now held to monitor review dates. However, we saw guideline updates were not always conducted in a timely way. The Maternal Early Warning Scoring and SBAR Tool Guidance version two, 2014, was still being reviewed by a consultant and the review date was October 2017. The trust's audit team monitored guideline compliance with NICE guidance. The trust's librarian team monitored when guidelines required updating in response to NICE or national guideline updates and circulated to the appropriate individuals for updating. Consultants were now more engaged with this process and took ownership and responsibility for reviewing guidelines in a timely way.
- However, staff were concerned leadership and oversight in the maternity department regarding checking policies

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and guidelines was insufficient. Staff felt this was reactive and enough was not being done to ensure policies were up-to-date in order to prevent incidents. We were provided with an example of when there had been an issue with the updating of a guideline.

- A new clinical quality midwife had been appointed and completed work to ensure guidelines were updated. There was now a greater understanding and less resistance from consultants which improved compliance to guidelines. Consultants were required to review documents specific to their areas of expertise. Staff signed to confirm they had read guideline updates.
- In addition, we saw evidence the service had implemented procedures to manage staff who were openly not adhering to guidelines and procedures.
- The service had a clinical audit programme which included 18 audits.
- The service was part of the first wave for piloting the National Bereavement Care Pathway (NBCP). The pathway aimed to improve the overall quality and consistency of bereavement care for parents and families. As part of the pilot, the pathway included five pregnancy or baby loss experiences including miscarriage, termination of pregnancy for fetal abnormality, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months.
- Patient's mental health was assessed at every appointment and was discussed during handovers.

Nutrition and hydration

- Staff appropriately assessed patient's nutrition and hydration needs.
- Patients were supported to feed their baby using their chosen feeding method for as long as they required. The service had a new-born infant feeding guideline which was up-to-date and reviewed in September 2017 which referenced the 'Postnatal care up to 8 weeks after birth NICE 2015 Clinical Guideline.' In addition, the maternity service was working towards gaining UNICEF Baby Friendly accreditation. We saw this was an improvement to our previous inspection where we identified patients were not always given correct infant feeding advice as the service did not use current guidance. Women were encouraged to hand express in the first three days post birth.
- The service had breastfeeding support workers and close links with a local infant feeding support group to assist patients to feed their babies. There were two

part-time breastfeeding support workers in maternity services (equivalent to one whole time equivalent). Maternity staff worked alongside a Health in Pregnancy Service (HIPS) to advise on breastfeeding.

- In addition, there was also a part time Health in Pregnancy Support Worker who staffed the telephone line (equivalent to 0.5 whole time equivalent).
- Patients we spoke with felt supported with feeding their baby. We spoke with a patient who was planning on visiting the breastfeeding team for breastfeeding advice. We saw a breastfeeding referral process on the service's electronic system. However, some staff told us breastfeeding support provision was insufficient. A midwife was supporting breastfeeding whilst the service was accessing additional breastfeeding support.
- The trust target for initiation of breastfeeding within 48 hours was 66% as set by commissioners. From April 2017 to March 2018, the service met the target for three months: 69.55% in May 2017, 67.57% in June 2017 and 66.05% in July 2017. For the remainder of the nine months, initiation rates were below the target and ranged from the lowest initiation rate in December 2017 at 55.04% and the highest compliance at just below the trust target at 64.53% in August 2017.
- Breast feeding initiation rates were recorded on the maternity dashboard. However, between November 2017 and April 2018, this was recorded for only two of the six months. The data for November 2017 and December 2017, 62.32% and 53.60% respectively also differed to the breastfeeding initiation rates we received from the trust following our inspection at 64.49% and 55.04%.
- We saw a pregnancy and new-born information leaflet was provided to patients which included feeding information.
- During our inspection, we found two fridges on the wards used to store breast and part bottles of formula milk were unsecured posing a potential of being tampered with. This had been a concern at our previous 2017 inspection. We raised this with senior staff on the first day of our inspection. When we returned the following day, we saw the trust had addressed this by ensuring both fridges were secured. The fridges were also locked during our inspection visit on 12 June 2018. The service acted promptly to address the issues we identified. However, the service should monitor that the fridge is locked at all times.

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- Staff checked patient's hydration levels during and post-delivery. Fluid balance charts we checked across all areas of the department appropriately documented patient's fluid intake and were up-to-date.
- Patient records we reviewed showed dietary and nutritional advice was given during antenatal appointments and staff recorded any patient dietary concerns.
- Cold food and drinks were offered to patients. In response to patient feedback, hot food was made available to patients who had an extended stay.

Pain relief

- Staff appropriately assessed, managed and administered patient pain relief. Anaesthetists were available on the delivery suite to provide patient's pain relief and to attend to emergencies 24 hours a day.
- Patients we spoke with told us they had received pain relief in a timely way. This was an improvement from our last inspection. We saw patients were given epidural information cards to inform them of the epidural pain relief process.
- Senior staff had oversight of pain relief provision and audited three sets of patient's notes each week to check whether patient's pain relief had been appropriately managed.
- The service did not currently audit the median time from patients requesting an epidural to receiving one or the number of women given an induction who were given appropriate pain relief in accordance with NICE guidance, CG70, July 2008. Patients should receive an epidural within 30 minutes of requesting one.
- However, service leaders closely monitored any delays in epidurals as part of the safety huddle which took place three times a day. This information was collated and reviewed for the monthly Divisional Director report. Delays in pain relief were also reported in this way along with delays in inductions. Any delays which related directly to midwifery staffing levels were reported as red flags on the Birthrate Plus Intrapartum Acuity Tool. Delays in pain relief were also included in the weekly/monthly report information provided to CQC.
- The delivery suite had birthing pools available for patients to have a water birth to aid with pain relief during birth. From November 2017 to April 2018, the birthing pool had been used on 97 occasions.

- Patients told us they received pain relief in a timely way and staff offered them a variety of different pain relief methods. This included complimentary therapies such as reflexology and aromatherapy.

Patient outcomes

- We saw senior service leaders regularly reviewed the effectiveness of care and treatment through local and national audit. The service had an audit team who coordinated audits and monitored audit results.
- As of June 2018, the service had no active maternity outliers.
- The trust took part in the Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE Audit) of UK Perinatal Deaths for Births from January to December 2016. Their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) had improved from 5.47 per 1,000 births to 5.09 per 1,000 births (up to 10% higher than the average for the comparator group).
- Actions had been put in place in response to the MBRRACE audit results, to reduce morbidity and mortality, this fed into the saving babies lives care bundle and Clinical Negligence Scheme for Trusts (CNST) incentive scheme.
- The maternity service used a local maternity dashboard to record activity and clinical outcomes. Where possible, included national targets to allow the service to benchmark the service's performance. The dashboard also included locally set targets where appropriate for internal monitoring purposes.
- Between April 2017 and March 2018, there were 163 planned and unplanned admissions to the neonatal unit (NNU). The number of term and avoidable admissions to the NNU had recently been added to the maternity dashboard for monitoring purposes. In addition, all term admissions to NNU dating back from January 2018 were being reviewed by a multi-disciplinary team of midwives, obstetricians and neonatologists to collate any learning.
- At our previous June 2017 inspection, the caesarean section (CS) rate was consistently higher than the national average of 25%. Between January 2016 and December 2016, the combined C-section rate was 31.5%. However, between January 2017 and December 2017, this rate had reduced by 3% to 28.9%.
- The service monitored caesarean section rates closely by holding caesarean section reviews, daily discussions

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were held at handover and through the clinical audit programme. The service held morning reviews of caesarean sections where C-sections for the last 24 hours sections were reviewed. Senior staff reviewed findings with the maternity governance team in detail to determine learning. Learning was shared with staff at multidisciplinary teaching meetings and as part of CTG review meetings.

- The service audited post-natal re-admissions. The number of readmissions within 42 days of delivery was recorded on the maternity dashboard. From November 2017 to April 2018, there were 39 re-admissions. We reviewed an audit from August 2017 to October 2017 where there were a total of 31 postnatal re-admissions. This was a readmission rate of 3.38%. We saw the main cause of readmission was due to infection at 12 readmissions. The associated action plan did not appear to clearly identify improvements.
- Staff reported any babies born before arrival (BBA) via the trust's electronic incident reporting system. The service would conduct an investigation and lessons learned and shared.

Competent staff

- Overall, maternity staff had the right qualifications, skills, knowledge and experience for their role.
- At our previous inspection, we identified there were insufficient midwives with HDU training to ensure that women in HDU were cared for by staff with the appropriate skills. This formed part of the enforcement action we took against the trust in September 2017. Some midwives were caring for women who required HDU care but had not completed HDU training.
- At this inspection, we found this had improved and the service planned to have two HDU trained midwives on each shift. The service implemented a process to incident report when a patient required HDU care and no HDU trained staff were available. HDU training completion had improved and staffing plans included two HDU staff covered each shift. This information was also included in the weekly/monthly data the service shared with CQC.
- All staff groups showed an improvement in appraisal rates from January 2018. The largest improvement was seen for medical staff.
- Staff told us they were supported by senior staff to conduct appraisals, were given sufficient time to hold them. Staff told us the new team leader approach had

ensured appraisals were more useful. Service leaders told us improving appraisal rates was a priority and this was evidenced by improvements in appraisal rates between May 2017 and April 2018.

- The service told us they were committed to the implementation of the national A-Equip model supported by the development of Professional Midwifery Advocates to support staff. This replaced the previous Supervisors of Midwives (SoM). Four newly trained midwives were conducting the training for this role with one previous SoM to conduct the short course. Senior staff told us they aimed to have 10 PMAs in future. Band 5 and staff requiring additional support would have one-to-one PMA support. A seconded Lead PMA post for a period of 12 months was also in the recruitment phase to support the implementation. The PMA role would be incorporated into the midwifery workforce plan which was currently under review. In order to implement the model as soon as possible the service planned to use a graduated plan.
- At our previous inspection, midwives were regularly required to act as scrub practitioners to assist in operating theatres. We saw this had improved from our previous inspection as theatre directorate staff were now used to scrub. This freed up midwives to concentrate on patient care as a midwife would still be in theatre to receive the baby.
- Student midwives conducted a comprehensive four-week induction programme when starting their role on the unit. In addition, student midwives followed a detailed preceptorship programme. During our previous inspection, student midwives told us they were regularly left unsupervised which had posed a risk to patients. We saw this had improved as student midwives we spoke with felt well supported. They told us they were supervised always throughout their preceptorship programme and more senior colleagues were supportive and encouraging.
- Community midwives rotated onto the maternity wards and delivery suite to maintain their skills and competencies and help cover unfilled shifts. However, some community staff felt they needed more experience of assisting births on the delivery suite as they were more confident with home births. Community staff knew how to, and when to escalate on the delivery suite but felt they did not have sufficient skills which made them feel uncomfortable working on the delivery suite.

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- Funding had been secured for all staff to complete human factors training. Courses were available for staff to attend each month. Almost all consultants had completed this training.
- The service had secured funding for 170 midwives to conduct Phi strategic leadership programme training. This learning is used to develop leadership skills of midwives. This training is endorsed and supported by the Royal College of Midwives as the need to provide opportunities for midwives to develop leadership skills had been widely recognised.
- The practice development midwife described the educational strategy for the service. This included PROMPT and mandatory training, closely monitoring staff training attendance and communicating to managers when staff missed training sessions or were not up-to-date with training. The Practice development midwife held a database to record staff training attendance records.
- The service had produced a development programme for newly registered midwives and midwives new to the trust who had not yet attained a band 6. The programme aimed to provide staff with a consolidation period to facilitate the transition from a student to a qualified midwife.
- The bereavement service was implementing bereavement study days for midwives and medical staff led by the bereavement midwife. The bereavement midwife was also arranging external study days with charity groups such as SANDS (stillbirth and neonatal death charity).
- There had been an increase in the amount of opportunities for hospital based and community staff development which had been a concern in the past. Community staff had been on secondments to widen their skills. The service had also offered development opportunities to maternity support workers (MSW) as they were given competency booklets to complete. This had been well received by MSWs we spoke with.
- Leaders of the service identified and managed poor or variable staff performance. For example, repeat offenders of incomplete completion of CTG documentation were held to account. Additional training and competency checks were offered as a supportive measure. Staff were taken through disciplinary processes if necessary.
- All necessary staff, including those from different teams were involved in assessing, planning and delivering care and treatment to patients.
- Staff told us they could access medical support in a timely way when required.
- We observed effective communication between consultants and all levels of staff, including midwives. Consultants told us relationships with midwives had improved and there was better communication with team leaders. However, some medical staff believed there was still scope to improve some aspects of communication.
- Community midwives had effective multidisciplinary team working with midwives, health visitors, GPs and social services. Community midwives collaborated with the health visiting team to appropriately transfer women to their care.
- However, a number of staff told us multidisciplinary working relationships with anaesthetists required improvement. A new doctor did not know the names of anaesthetists four months after their commencement and told us anaesthetists were not involved in doctors' development. In addition, staff told us some anaesthetists did not support the HDU ward round and they needed better engagement from anaesthetists to provide safe HDU care. Staff said: "it feels like an outreach anaesthetist service."
- If staff had concerns regarding a patient's mental health, they could contact the perinatal mental health team for support.

Seven-day services

- The maternity service at Walsall Healthcare NHS Trust provided care and treatment to patients and their babies 24 hours a day, seven days a week.
- The Fetal Assessment Unit was open from 9am to 5pm, Monday to Friday.
- The Early Pregnancy Assessment Unit was open Monday to Thursday from 8.30am to 5.30pm and on Fridays from 8.30am to 1pm.
- Following our last inspection, the senior leadership team closed the Midwifery Led Unit (MLU) in July 2018 to mitigate risks to women and their babies as the maternity unit had challenges with meeting safe staffing levels in maternity. There were plans to utilise the MLU

Multidisciplinary working

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as a community hub, offering antenatal, postnatal and perinatal mental health clinics. Walsall Healthcare NHS Trust's Women Requiring Extra Nurturing (WREN) team would also be run from the MLU.

- Community midwives ran the home birth service and were available 24 hours a day, seven days a week. However, community staff no longer carried out home bookings as these were held in GP surgeries. This meant patients had to attend clinics and there was no availability for weekend appointments.
- The triage unit provided patients with 24-hour, seven days a week access to a midwife and/or an obstetrician.

Health promotion

- The service co-ordinated with the Health in Pregnancy service to promote healthy lifestyles during pregnancy. This included for example, health promotion initiatives such as smoking cessation.
- Pregnant women at any stage of pregnancy should be offered the influenza and pertussis (whooping cough) vaccination. The trust ran a pilot with NHS England in September 2017 to offer all pregnant women the influenza and pertussis vaccine at the antenatal clinic. Walsall Healthcare NHS Trust terminated this service in July 2017. However, the trust had not communicated the ceasing of this service to the pilot commissioner (Public Health England). This lack of communication meant that Public Health England were not aware that alternative provision for this service was required. This had led to patients not being offered the flu and pertussis vaccination. Patients had been signposted to their GP to obtain these vaccinations.
- We reviewed the serious incident report for this incident. The root cause analysis identified there was no clear action plan agreed by the maternity service at the trust to address the staffing requirements needed to allow the continuation of the pilot. The RCA highlighted there have been no known cases of pertussis as a result of the incident and based on this finding, the incident was downgraded to no harm. The trust took remedial actions and identified that a total of 351 women (from Walsall GP practices) had no confirmation of an offer of vaccinations made. A plan was established to ensure all of the 351 women who had no confirmation were offered the vaccination.
- The BCG (Bacillus Calmette-Guérin) vaccine is usually offered to babies who are at a higher risk than the general population of contracting tuberculosis (TB). We

saw there was a recorded risk on the maternity risk register regarding the potential for babies in high-risk groups contracting TB. The maternity service at Walsall Healthcare NHS Trust was unable to vaccinate all babies before transferring them into community care due to a global shortage of BCG vaccines. Babies had been having to wait up to 12 weeks for the vaccination and may not have been sufficiently protected from contracting TB and there was a potential for babies to be lost to follow up. In an attempt to mitigate this risk and address the 12-week waiting list for vaccination of babies, the trust was running additional clinics. However, information received from the trust showed the BCG vaccination waiting time had reduced. As of 4 May 2018, the waiting time had decreased to three weeks and by 14 June 2018, this had decreased further to one week.

- Patients were screened for MRSA and C.Difficile. There had been no cases of MRSA and C.Difficile during the last 12 months.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about the basic principles of consent and Mental Capacity Act 2005. We saw staff appropriately gained patient consent for treatment in accordance with legislation and guidance. Records we checked confirmed this.
- As at April 2018, Mental Capacity Act (MCA) training had been completed by 97.94% of maternity staff and Deprivation of Liberty Safeguards training had been completed by 97.12% of maternity staff. This was an improvement from our previous inspection. The service was due to implement training for midwives in post-mortem consent. Training in taking consent for perinatal post mortems was being undertaken by 12 Midwives and two doctors.

Are Maternity (inpatient services) caring?

Good



We rated caring as good because:

- Overall, patients reported positive care experiences.
- We observed all staff interactions with patients were caring and supportive.

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- Patients received compassionate and supportive care for as long as they needed.
- Staff protected patient's dignity and respect at all times and in particular for intimate examinations.
- Staff explained care and treatment to patients and families in a way they could understand.
- One patient told us they had received "very good emotional support during birth and readmission."
- Numerous thank you cards were displayed across the department from patients praising

the emotional support provided by staff at challenging times.

- The bereavement midwife offered patients emotional support following pregnancy loss.
- Staff at all levels supported one another following neonatal and maternal deaths. Additional support was also available from the bereavement midwife if required.
- The transitional unit was a useful addition to postnatal care as parents could stay with their baby whilst their baby received this extra support.
- The service acted on patient feedback to improve the service.

However;

- From May 2017 to April 2018, the trust's average Friends and Family Test results were lower than the England average; with the exception of the postnatal ward results which were similar to the England average.

Compassionate care

- Without exception, we observed all staff interactions with patients were caring and supportive. Staff treated patients with dignity and respect at all times by pulling curtains around during intimate examinations.
- Staff took time to interact with patients and partners in a respectful and considerate way.
- Staff respected patient's confidentiality at all times including holding staff discussions and handovers regarding patients' care and treatment away from the patient ward and bay areas.
- One patient told us "all doctors and midwives have been kind." Another patient told us staff were "helpful and friendly, amazing care, best care available."

- From May 2017 to April 2018, the trust's average Friends and Family Test (FFT) results were lower than the England average; with the exception of the postnatal ward results which were similar to the England average.
- Staff in maternity were encouraged to increase the use of electronic tablets to aid in improving quality of FFT feedback and to promote accessibility. Paper copies were also available.
- The service took part in the Care Quality Commission maternity survey each year. This provided useful feedback to the maternity service, which could be used to improve patient experience. In the CQC maternity survey 2017, responses were received from 92 patients regarding maternity care received at Walsall Healthcare NHS Trust. The trust performed "about the same" as other trusts for 18 questions and worse than other trusts for one question:
 - For the four questions relating to labour and birth, the trust performed "about the same" as other trusts for three of the questions:
 - Regarding receiving appropriate advice and support advice at the start of labour
 - Regarding being able to move around and choose the most comfortable position during labour.
 - Regarding partners being involved as much as they wanted.
 - However, the trust performed worse than other trusts regarding labour:
 - Regarding having skin-to-skin contact with the baby shortly after birth.
- For the questions relating to staff during birth, the trust performed about the same as other trusts for all eight questions. This included: staff introductions, not being left alone, raising concerns, attention during labour, clear communication, involvement in decisions, respect and dignity and confidence and trust in staff.
- For all seven questions relating to care in hospital after birth, the trust performed "about the same" as other trusts. These questions referred to: length of hospital stay, delay in discharge, reasonable response time after birth, information and explanations, kind and understanding care, partner length of stay and the cleanliness of their hospital room or ward.

Emotional support

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- One manager had secured charitable contributions to fund a counselling room in the outpatient's clinic. This allowed difficult and confidential discussions to take place in a more pleasant and private environment.
- Patients were referred to an external specialist pregnancy loss counselling service for support. However, the service told us feedback from patients highlighted the waiting list was lengthy.
- Patients told us staff were reassuring and remained calm even during an emergency situation which helped alleviate their distress. One patient stated they would recommend the maternity service and "staff are really good."
- Staff held debriefs following neonatal and maternal deaths and supported one another emotionally. One midwife gave us a recent example of when a leader of the service provided a midwife with emotional support following a neonatal death. Additional support was also available from the bereavement midwife if required.
- The bereavement midwife had close links with a bereavement charity to provide an additional emotional support network to bereaved patients and their families.
- One patient told us they had received "very good emotional support during birth and readmission."
- Numerous thank you cards were displayed across the department from patients praising the emotional support provided by staff at challenging times.
- Patients were supported in choosing their birthing method which was indicated in personalised care plans. Patients' partners and family members told us they felt well informed about care and treatment of patients. This was an improvement from our previous inspection.
- The inpatient matron for the maternity department carried out weekly patient experience audits. We reviewed results from April 2018 to May 2018. They reported overall positive comments from patients. For example, "staff have been lovely, pain relief and water on time, staff came quickly when the buzzer was pressed." Another comment stated: "midwife helped me feed my baby after delivery, thank you."
- The only negative responses were in relation to a noisy environment: "bit noisy in bay at night" and lack of hot food: "only had sandwiches, would have liked a hot dinner." The service used feedback to improve patient experience. Senior staff alerted staff about minimising noise levels at night and patients on the delivery suite who had a prolonged stay were to be offered hot meals on the delivery suite.
- Staff with the support of the bereavement midwife provided bereaved families with appropriate information and support regarding making memories with their babies if they wished to.

Understanding and involvement of patients and those close to them

- The service's four-bed transitional care unit offered additional support for babies who did not require admission to the neonatal unit, but may have been born prematurely or required extra care or monitoring before being discharged home. This was positioned on the ward. This was a useful addition to postnatal care as parents could stay with their baby whilst their baby received this extra support.
- Patients told us they were allocated a named midwife at their initial booking appointment which provided continuity of care.
- Patients confirmed staff introduced themselves and explained tests and procedures in simple terms to ensure they could understand.

Are Maternity (inpatient services) responsive to people's needs? (for example, to feedback?)

Requires improvement 

We rated responsive as requires improvement because:

- There was limited availability of accessible information in different languages, picture formats, and cue cards. The use of the translation phone service was variable and did not always protect patient privacy.
- Some staff told us the senior maternity team and consultants did not have the discharge process as a priority.
- The service did not currently have any internal services dedicated for counselling parents who had experienced the loss of a baby.

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- The closure of the MLU had improved staffing levels in the acute setting however, women who may have chosen to birth in the MLU may not have access to the same facilities and equipment to support a normal birth on the main site.
- The service regularly had a shortage of wheelchairs available and we did not see any bariatric chairs available for patients with a raised BMI (heavier patients).
- Data provided by maternity services showed not all women had been seen antenatally by 10 weeks in accordance with NICE QS22 statement 1 guidance: Services – access to antenatal care.

However:

- Since our last inspection, the service had put measures in place to consider and better meet the needs of the local population.
- Specialist had been appointed to provide specialist support to patients.
- The bereavement team supported patients and those close to them following pregnancy loss.
- The bereavement midwife supported patients and relatives to meet their spiritual and religious needs in conjunction with the trust's chaplaincy service.
- Patients told us antenatal appointments were flexible and easy to arrange.
- Patients understood the complaints process and information was displayed in patient areas about how to complain.
- Service leaders took complaints seriously and maternity staff were supported by the governance team when a complaint was received
- The service co-ordinated with the Health in Pregnancy service to promote healthy lifestyles during pregnancy.
- Service leaders discussed complaint themes and actions implemented in response with staff at team meetings.
- The maternity service worked with the 'Walsall Maternity Voices Partnership' to design services to meet the needs of the local population.
- The department had received a low number of formal complaints.

Service planning and delivery to meet the needs of local people

- Since our previous inspection, maternity services had appointed some specialist midwives to meet the needs of the local population. This included a lead midwife for normality and a specialist safeguarding and vulnerable women midwife. The vulnerable woman midwife role provided teenage pregnancy support for the service. Specialist antenatal clinics were provided such as HIV, female genital mutilation, fetal medicine, diabetic, VBAC and anti-D.
- The service had a dedicated maternity physiotherapist. The trust offered a free weekly drop-in session for antenatal women to offer physiotherapy advice throughout pregnancy and to help deal with aches and pains.
- The Divisional Director of Midwifery, Gynaecology and Sexual Health now had a deputy and all matrons in post to support their role which enabled future service planning to take place.
- The service had facilities for partners to stay. Visiting times for partners and relatives were flexible.
- The maternity service worked with the 'Walsall Maternity Voices Partnership' to design services to meet the needs of the local population. The aim of the forum was to involve parents and stakeholder representatives in the development and improvement of the maternity services at the trust and local region and to shape maternity services to meet the local population needs.
- Patient information leaflets were available covering a variety of pregnancy related topics. Some information could be downloaded in different languages if required. However, there was limited availability of information in languages other than English.
- Alert flags were added to patient records to identify certain support required, such as those patients who had been victims of female genital mutilation.
- Patients were allocated a named midwife at their initial booking appointment to provide continuity of care.
- Asylum seekers, travellers and migrants were supported by a designated health visitor.

Meeting people's individual needs

- Overall, patients reported positive experiences whilst in the unit which included partner involvement.
- The service co-ordinated with community midwives and GPs to direct patients to the most suitable services. This ensured patients had continuity of care and support when transitioning from hospital-based to community care arrangements.

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- The service had a dedicated bereavement midwife who led the maternity bereavement service.
- The department had a service for screening for fetal abnormalities. High-risk women could attend the fetal assessment unit after 20 weeks gestation. The early pregnancy assessment unit was available to patients up to 20 weeks gestation. Patients could access these clinics almost immediately when required.
- The antenatal clinic had dedicated counselling rooms to hold sensitive discussions in private.
- The department was wheelchair accessible with some wheelchairs available for use. However, staff told us there was regularly a shortage of wheelchairs available. We did not see any bariatric chairs available for patients with a raised BMI (heavier patients).
- Chaperones were available for patients if requested. We saw signs across a number of areas of the department notifying patients that chaperones could accompany them. Staff documented in patient's notes if a chaperone had supported patients.
- The vulnerable women's midwife had recently started a clinic to support patients with post-natal depression. Midwives discussed patient's mental and emotional wellbeing at each contact and understood how to respond if they had any mental health concerns. The perinatal mental health team could provide additional mental health support if required.
- The trust had a Health in Pregnancy Service which worked alongside midwives and maternity staff to provide patients with information regarding a variety of health issues
- Sign language translators were available and staff had identified a need for visual aids which were currently not available.
- There was limited availability of accessible information in different languages, picture formats, and cue cards. Translation telephone services were accessible for patients whose first language was not English. These could be accessible at weekends and out-of-hours. On the wards, there was no portable phone available so patients had to use the phone by the nurse's station to have confidential conversations, this meant conversations could not be held in private.
- We saw some menus had options to meet the cultural needs of patients. However, we did not see menus available in picture format. Staff told us these were available in other parts of the hospital but not on the maternity unit.
- The vulnerable patients midwife supported patients with learning disabilities. The service had effective systems in place to identify where patients had additional support needs.
- The delivery suite had some equipment such as birthing balls, birthing pools, mats, and birthing stools to support low risk patients to have an active birth.
- Community staff told us some patients were informed they could not have waterbirths as it was not available.
- The service ensured a post-mortem examination was offered in all stillbirth and neonatal death cases from 16-week gestation in order to improve future pregnancy outcomes for parents. In addition, all patient's placentas were sent to another trust for histology testing. Training in taking consent for perinatal post mortems was being undertaken by 12 midwives and two doctors.
- We saw the service provided patients with a detailed 'Your Personal Maternity Record' along with a postnatal and new-born information booklet at their first booking appointment. This described all aspects of the pregnancy journey through to postnatal care following discharge from the department.
- The maternity service provided patients who had suffered an intrauterine death or had fetal abnormalities, a termination of pregnancy (ToP). The service conducted ToP for patients whose pregnancy was ending due to fetal loss after 20 weeks gestation and for intrauterine death after 24 weeks gestation. There was a policy in place detailing the procedure which had been fully updated in August 2017.
- The service had an agreement with a specialist trust to transfer patients with any serious abnormalities to their tertiary centre. We reviewed the detection of a fetal abnormality (management of a pregnancy following the detection of a fetal abnormality) policy which covered this process. This outlined the local Fetal Medicine staff should complete a referral form which must to the Fetal Medicine department at the tertiary centre, with relevant contact details for the woman and details of the referring Consultant. This policy was up-to-date.
- The service had secured funds to implement a dedicated perinatal mental health team to include an on-site consultant psychiatrist and community psychiatric nurses.
- We did not speak to any bereaved parents directly however, we looked at what was in place to support them emotionally through their loss. The service ensured families could spend as much time as possible

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with babies they had lost in the bereavement suites. Cold cots were available to lengthen the time families could spend with their baby. The service had recently produced a policy detailing the procedure if families wished to take their babies body home to be with their baby in private.

- Staff supported patients and those close to them to make special memories with their babies they had lost. The service had a dedicated camera for use on the labour suite to enable families to take photographs. Memory boxes were provided to all families.
- The maternity service ensured all planned appointments were cancelled when a patient had experienced pregnancy loss. GPs were updated to ensure they were aware of the pregnancy outcome.
- The service was due to implement training for midwives in post-mortem consent.
- A bereavement midwife post had been implemented in maternity services since our last inspection. Staff supported patients following their loss during their stay in the department as well as once they had been discharged home. The bereavement midwife told us they would home visits to provide bereavement support to patients and their families if required. They described a clear vision for the development of the bereavement service, this included robust follow-up support for patients and the development of a larger bereavement team.
- The trust was part of the first wave for piloting the National Bereavement Care Pathway (NBCP). The pathway aimed to improve the overall quality and consistency of bereavement care for parents and families. As part of the pilot, the pathway included five pregnancy or baby loss experiences including miscarriage, termination of pregnancy for fetal abnormality, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months. These pathways have been implemented into maternity, gynaecology, the neonatal unit, fetal medicine and screening services. The service also aimed to include accident and emergency and community services into the pathway.
- The service ensured patients and those close to them were provided with appropriate support including funeral, burial or sensitive disposal of pregnancy remains when patients had suffered early pregnancy loss.

- The specialist bereavement midwife co-ordinated with the trust's chaplaincy team to support patients and those close to them with funeral or burial arrangements. The chaplaincy team had representatives from various faiths: Christian, Muslim, Sikh and Hindu and close links with other faiths. Staff supported parents to have their babies released as soon as possible to allow for the funeral to be held quickly where this was an important aspect of their faith.
- The bereavement service organised an annual babies memorial service in conjunction with the trust's chaplaincy service. This provided an opportunity for parents, families and hospital staff to remember babies they had lost and gave them an opportunity to light a candle in their memory.
- Currently the UK law states that babies born before 24 weeks cannot be legally registered.
- The bereavement service produced their own version of a 'birth certificate' for families who wished to receive them to formally recognise their babies.
- We saw an example of a patient with additional learning needs requiring mental health support postnatally. We saw midwives had completed a care plan and signposted the patient to appropriate mental health support services.
- The service did not currently have any internal services dedicated for counselling parents who had experienced the loss of a baby. However, the specialist bereavement midwife and a community midwife were studying a diploma in grief and bereavement counselling. This was with the aim to provide a holistic care pathway to provide additional continuity of care in maternity services for patients.

Access and flow

- Patients we spoke to in the antenatal clinic told us they could make appointments at a convenient time and they found it easy to make an appointment. Patients could be at the antenatal clinic for a number of hours to be seen for all their appointments and tests. However, this was to ensure patients had all procedures on one day rather than over separate days.
- Pregnant women should be supported to access antenatal care ideally by 10 weeks in accordance with NICE QS22 statement 1 guidance: Services – access to antenatal care. The service recorded the number of patient bookings taken by 12 weeks. However, data between May 2017 and April 2018 showed not all

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women were seen by 12 weeks. Compliance ranged from its lowest rate in November 2017 at 84.47% to highest compliance levels of 91.05% in June 2017. Senior staff in the maternity service were confident they were booking all patients within the correct time period however data provided did not support this. Staff believed data collection issues were not providing this assurance and were aware that the data collection required further work to validate this.

- Staff assessed patients' needs in the triage area on arrival to the maternity department. Patients were triaged to the most appropriate area of the maternity unit according to their pregnancy stage. Patients could contact the triage department for advice. Calls were not currently recorded but we saw plans this was to be implemented to have a record of advice given. Patients could call the triage unit up to a maximum of three occasions in one 24-hour period. On the third call, staff would always advise the patient to attend the unit in person or before if assessed as needed.
- The maternity service offered patients at beyond 20 weeks gestation a termination of their pregnancy for medical reasons. This was outlined in the medical management for termination of pregnancy for fetal abnormalities/ intrauterine death within maternity services guideline.
- The service ran a vaginal birth after caesarean (VBAC) clinic, this was midwife led for patients who had previously had caesarean sections to discuss birth options for their next birth. We saw the waiting times for the VBAC clinic were over four weeks, which was recorded on the maternity risk register.
- From April 2016 to March 2017, the maternity unit was closed on 10 occasions due to staffing shortages. During this inspection, we found from May 2017 to April 2018 the maternity had not been closed. However, the MLU remained closed from July 2017 to improve staffing levels across the unit.
- The trust's neonatal unit was a level 2 unit which cared for babies above 28 weeks gestation. If babies required level 3 neonatal care, they would be transferred to a neighbouring trust.
- There was a discharge room next to the antenatal and postnatal wards for patients to wait whilst staff completed the discharge paperwork. Some staff told us

the senior maternity team and consultants did not have the discharge process as a priority. Staff felt there was an on-going conflict between the delivery suite and consultants regarding discharge planning of patients.

- The service monitored when patients did not attend antenatal appointments. Clerical assistants printed off a list of patients who did not attend at the end of each day. Midwives checked the list and contacted patients to re-book appointments.
- The maternity service's average bed occupancy rate in 2017-18 was lower than the England average of 59.3% at 57.3%; within that period, 15 days had 100% bed occupancy.

Learning from complaints and concerns

- Service leaders took complaints seriously and maternity staff were supported by the governance team when a complaint was received.
- The department had received a low number of formal complaints. Formal and informal complaints maternity were recorded on the maternity dashboard. From June 2017 to April 2018, there had been 11 formal complaints regarding the service. During the same time period, there had been 51 informal complaints. Team meeting minutes showed complaint themes were shared with staff. Learning and changes to practice in response to complaints formed part of the complaints process.
- We saw Patient Advice and Liaison Service (PALS) posters and leaflets displayed throughout the unit advising patients how to complain. An easy read leaflet was also available explaining the complaints process.
- Patients we spoke with knew how to complain if required. During our inspection, a patient and family member raised concerns with us about some aspects of their care and treatment. We raised this with the senior maternity staff during the inspection. They promptly arranged to meet with the patient and relative to discuss the concerns they had. By holding this discussion, this alleviated the families' initial worries and negated the need for the family to raise a formal complaint.
- The maternity governance meeting minutes for April 2018 referenced a recurrent trend in patient complaints due to the lack of breastfeeding support. A midwife was supporting patients to breastfeed whilst the service accessed additional breastfeeding support provision.

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Are Maternity (inpatient services) well-led?

Requires improvement



We rated well-led as requires improvement because:

- Although service leaders recognised further leadership improvements were required, we were not wholly assured the pace of change was sufficient to drive improvement in a timely way.
- Some staff felt improvements in planning for the service still required further improvement.
- Some long-standing midwives felt excluded as they perceived they had fewer opportunities than recently recruited midwives.
- The coherence of some consultants required further improvement.
- Some staff felt they were not sufficiently involved in discussions regarding the closure of the MLU. We did not see a plan in place to re-open the MLU to accept patients to birth there.
- Some cultural issues remained an issue with some pockets of staff and reports of staff undermining other staff.
- Senior staff needed to continue to accept and address the concerns identified in maternity services and maintain the pace of change.
- The maternity improvement action plan did not sufficiently document specific individual actions identified by the 2017 CQC report or external reviews of culture in the maternity service.
- Service leaders did not sufficiently prioritise or support the normality agenda.
- Governance was more organised and process driven but there was still a long way to go to be fully functional by ensuring all staff were fully engaged with the governance process of the department.
- Some risk review dates on the local risk register had expired and there was no indication of progress made. We were therefore not assured senior leaders were monitoring risks that had ongoing actions sufficiently and updating the risk register accordingly.
- Staff in the maternity department were motivated and engaged with driving improvement for the service. This was an improvement from the previous inspection however further improvement was required.

- We saw the service learned from serious incidents and never event investigations. Overall, lessons were shared with staff but this still required some improvement.
- Improvements in the sustainability of the service and in particular improved staffing levels in the hospital setting had been partly achieved by having a birth cap in place and closing the midwifery led unit. We had concerns that the service may not be sustainable if the unit was delivering to its capped level and the midwifery led unit re-opened.

However:

- Since the last inspection, the service now had a leadership structure in place with clear lines of escalation. The corporate leadership team and frontline staff were more linked and confidence in leaders had improved.
- The culture of the service had improved from our last inspection. However, pockets of cultural problems still remained.
- Service leaders and members of the trust's executive team demonstrated they had improved oversight of the challenges the maternity service was facing.
- Staff felt their contributions to the maternity service were more valued by the senior leadership team.
- Community staff told us they felt well supported by the community leaders who formed part of the changed leadership structure.
- Junior doctors told us the maternity leadership team were approachable and they felt comfortable to raise issues with the Clinical Director if necessary.
- The maternity service leaders had developed a clearer vision and strategy for the service compared to our previous inspection. This included expanding the bereavement service provision.
- Senior staff were most proud of the improvement in staff morale and staff engagement in the improvement journey of the service.
- The local maternity risk register documented the main risks to the service.
- A new dedicated purpose built second theatre was being constructed which mitigated risks identified at our previous inspection relating to the suitability of the second theatre.
- Following the inspection, we saw evidence the service had implemented procedures to manage staff who were openly not adhering to guidelines and procedures.

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- The maternity service supported a multidisciplinary forum 'Walsall Maternity Voices Partnership' which met quarterly.
- The maternity service had been nominated for an award in transitional care.

Leadership

- The maternity service was part of the Women's, Children's and Clinical Support Services (WCCSS) division. The maternity department was led by the Divisional Director of Midwifery, Gynaecology & Sexual Health and the Clinical Director.
- Since the last inspection, the service now had a more stable leadership structure in place with clear lines of escalation. The corporate leadership team and frontline staff were more linked and confidence in leaders had improved. However, leaders recognised further leadership improvements were required and we were not wholly assured the pace of change was sufficient to drive improvement in a timely way.
- Senior staff told us the leadership ethos had shifted from a reactive to more proactive approach. Having the Deputy Divisional Director of Midwifery, Gynaecology & Sexual Health in post and all matrons and team leaders in post further strengthened the leadership structure of the department. Service leaders and members of the trust's executive team demonstrated they had improved oversight of the challenges the maternity service was facing.
- At the time of our inspection, a consultant obstetrician held the interim Clinical Director post for maternity. Staff considered this deployment to be beneficial for the service as consultants became more involved and more willing to engage with the improvement process. Team working had improved and some barriers between staff had been broken down. Staff were working more flexibly to support one another and the improvement process.
- Leaders of the service told us they were embedding a 'bottom up' rather than a 'top down' approach in the department. This was to encourage staff at all levels to influence the service. Staff told us they now felt more listened to and would be happy to challenge and suggest new ideas. Staff told us they had seen an improvement in the leadership team taking some ownership for planning for the service. However, staff still felt further improvement was required.
- Community staff told us they felt well supported by the community service leaders who formed part of the changed leadership structure.
- Leaders of the service had conducted training on leadership styles and now had a greater appreciation of team member attributes and skills and ensure staff contribution was recognised.
- Overall, staff confirmed that leadership of the department had improved. Leaders of the service were visible on the unit and were described as approachable. Staff knew who the Divisional Director of Midwifery, Gynaecology and Sexual Health was as they were visible and accessible. Junior doctors told us the maternity leadership team were approachable and they felt comfortable to raise issues with the Clinical Director if necessary.
- Staff told us some of the leadership team were hands on when required. Staff gave an example of when a senior team member assisted on the delivery suite to support staff when the department was very busy.
- The Divisional Director of Midwifery, Gynaecology and Sexual Health held a one-to-one with every new starter in the department and the Deputy Director of Midwifery, Gynaecology and Sexual Health also visited the wards every day.
- Staff felt since the Divisional Director of Midwifery, Gynaecology and Sexual Health had started, matrons had also been more visible on the delivery suite.
- A number of recently qualified midwives had also been supported with leadership roles. This had been well received in general however, this had made some long-standing midwives feel excluded as they perceived they had fewer opportunities.
- The Divisional Director of Midwifery, Gynaecology and Sexual Health had direct access to the trust board via the Director of Nursing and Chief Executive but did not formally attend board meetings. They did have links to sub committees to provide improved outputs and processes by board members via governance meetings. A non-executive director represented the maternity service at board level.
- Community staff told us that working remotely made it more difficult to have regular contact with leaders but felt their managers were still easily accessible.
- Some senior staff told us one of their biggest worries was that the Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health role was not a

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permanent position. Staff recognised this role had been a vital addition to the leadership structure as this provided frontline maternity staff with additional support.

- Consultants told us the senior leadership team understood the pressures of the department and described them as very supportive and they listened to their concerns. Consultants described leaders of the service monitored improvements via a “robust maternity improvement plan which everyone understood.” This plan was presented at a monthly multi-agency oversight meetings and showed clear accountability with a timeline. Consultants told us the progress of the improvement plan from red to green to highlighting actions completed a big change for the department.

Vision and strategy for this service

- The maternity service leaders had developed a clearer vision and strategy for the service compared to our previous inspection. Staff were aware of the local vision and strategy for the maternity department. Senior staff told us the service had focused on the safe and well led domains for improvements over the last 12 months.
- Community staff told us they were well informed about how the community team formed part of the overall service strategy. However, whilst the vision and strategy for the department had greatly improved, not all staff were engaged with the process as they believed these were mainly emergency changes that have improved delivery suite working and safety but to the detriment of other areas and reduction in some patient choice.
- In response to having a new Chief Executive at the trust and maternity leadership team in place, the service planned the new strategy in line with the trusts refreshed strategic objectives and values.
- However, staff views regarding the communication of the MLU closure was mixed. Some staff said they had been involved in some discussions about the future of the MLU. However, other staff thought there had been insufficient communication with staff regarding the overall closure. We saw plans to run some outpatient clinics from the MLU but we did not see and staff were unaware of a plan in place to re-open the MLU to accept patients to birth there.
- The maternity service leaders worked in collaboration with maternity units and commissioners in the Black County region called Local Maternity Systems (LMS's).

The aim was to develop and implement a local vision for improved services and outcomes based on the principals outlined in the Better Births guidance. The Divisional Director of Midwifery, Gynaecology and Sexual Health attended the bimonthly regional Head of Midwifery (HoM) network meetings where good practice and learning from incidents was shared.

- This was reported as a good support network for the HoMs. The Divisional Director of Midwifery, Gynaecology and Sexual Health was also supported by a Head of Midwifery from another trust as this was their first Divisional Director of Midwifery, Gynaecology and Sexual Health position they had held.
- Leaders of the maternity service told us they were well supported by the trust board in particular regarding addressing the staffing shortfalls in the department. The Divisional Director of Midwifery, Gynaecology and Sexual Health did not attend board meetings but had access to the board via the Director of Nursing and CEO. They updated the board each month via the trust's management committee process.
- The service had a clear vision for the development of the bereavement service. This included additional follow-up support for patients and the development of a larger bereavement team; the bereavement team currently consisted of one bereavement midwife.

Culture within the service

- During our last inspection we identified the maternity department had significant cultural problems. Overall, we saw improvements in the culture of staff particularly on the delivery suite. However, cultural issues remained an issue with some pockets of staff and reports of some maternity staff undermining other staff.
- Staff confirmed culture in the maternity department had improved since the last inspection as the department overall worked well as a team. Overall, staff told us they had seen an improvement in the culture and relationships with clinicians and within midwifery teams since our last inspection. However, divisional huddles had not been well attended by clinicians where clinical engagement with governance remained an issue. The coherence of some consultants also required further improvement.
- Service leaders were most proud of how staff had “risen to the challenge” of driving improvement in the service. Staff were overall accepting of change and showed enthusiasm and flexibility to achieve this.

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- Staff were proud of the maternity service and we saw the culture was much more positive. Staff were also proud of reducing the caesarean section rate.
- Senior staff told us they were most satisfied with the improvement in staff morale. They told us staff had found it challenging following the last inspection dealing having to cope with the CQC inadequate rating of the service. Staff have significantly embraced the changes and morale improved as a result.
- Staff were proud of the recent improvements in the fetal assessment unit (FAU). Staff gave examples of patients attending the FAU in person to thank them for the care they had provided.
- The trust had held a number of events and external reviews in an attempt to address the cultural issues identified in the maternity unit. The trust commissioned an external review by the Royal College of Obstetricians and Gynaecologists in October 2017 in response to the findings of the 2017 CQC inspection. Following the CQC inspection in 2017, many staff were in denial regarding the issues identified in the maternity unit. However, the external reviews identified similar concerns to those found during the CQC inspection. The external review undertaken by the RCOG recognised some progress had been made however, there was still a requirement for further improvement and the pace of change needed to be enhanced.
- This led to staff being more accepting of the problems that needed addressing. Staff were more engaged with supporting the improvement cultural changes and working together as a team to drive this improvement. There had been a significant shift in the attitude of the majority of consultants who were reacting well to the changes required.
- Separate formal action plans had not been developed regarding the external reports review however, actions were included in the overall maternity improvement plan. The service provided details of actions that had been implemented in response to both reports. For example, an action from the RCOG report was for leaders of the service to conduct regular walkabouts of maternity areas. In response to the cultural review, only two examples were provided: individual development sessions scheduled with consultants commencing July 2018 and a further programme of work to be developed in addition to the RCM programme for a small number of midwives.
- We reviewed the well-led section of the maternity improvement plan (version seven). This included general actions taken to address cultural concerns. However, it did not sufficiently document specific individual actions identified by the 2017 CQC report or external reviews made in an attempt to improve the culture in the department.
- Staff told us certain areas of the department, were increasingly midwifery led. However, we found the model of midwifery care at the trust remained a mainly consultant-led service.
- Since our last inspection, the service had recruited a lead midwife for normality to promote active birth. However, we were not assured encouraging patients to have active births and developing the normality agenda was regarded as a priority. We saw little evidence leaders understood or supported normality. Since the closure of the MLU, the service had lost some MLU staff who had been passionate about promoting normal births.
- Staff were also positive about the way in which the whole maternity team had pulled together to rise to the challenge of improving the service. Staff were accepting of change and were enthusiastic about the improvement journey. In the recent 2017 staff survey results for the question, 'I am able to make suggestions to improve the work of my team or department,' maternity staff from the delivery suite state responded: 52% agreed with this comment and 13% strongly agreed. However, these results were slightly lower than the comparator (52% and 23% respectively).
- Junior doctors told us they felt listened to and were confident to raise concerns without the fear of retribution. They felt they had a forum to be listened to; they could go to Freedom to Speak Up Guardians, another consultant or education group. The person or forum they would go to would be dependent on the concerns they had. They were confident to raise concerns with the Clinical Director if necessary.
- Leaders of the service held six-week progress interviews with new staff to determine if they felt supported and to request information regarding the culture in the department. Overall, feedback had been positive with staff stating they were well supported.
- Some staff felt the divide between delivery suite and ward staff still remained. There was no formal rotation of staff apart from band 5 midwives who were on

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preceptorship programmes. Staff were deployed to areas of the department where they were most needed but staff fed back this was still not working as well as it might.

Governance

- The maternity department had a clear governance structure in place which was an improvement from our previous inspection. Staff told us they understood their roles and responsibilities and who they were accountable to. Governance was more organised and process driven but there was still a long way to go to be fully functional by ensuring all staff were fully engaged with the governance process of the department.
- Maternity services were part of the Women's Children's and Clinical Support Services Division. The service had implemented a Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health to support the Divisional Director of Midwifery, Gynaecology and Sexual Health. Staff told us this had been a beneficial addition to the leadership and governance structure. The service had recruited a consultant with a special interest in governance who would be in post from August 2018.
- Monthly oversight meetings were held to monitor the trust's progress against the improvements we told the trust they must action in the s29A warning notice we issued in September 2017. This had subsequently changed to monthly maternity taskforce meetings to concentrate on improvement in the maternity department. The trust, CQC and other stakeholders attended. The maternity improvement plan was presented at each oversight meeting which showed clear accountability for each action and evidenced improvement in all areas of concern we outlined in the 2017 warning notice.
- The service held divisional huddle meetings to discuss incidents, actions and learning to prevent reoccurrence.
- The department had a developing audit programme which included participation in local and national clinical audits.
- The service had a maternity safety champion who was a non-executive board member. A champion had been identified to lead a development in the community.
- The service held maternity governance group meetings each month. We reviewed meeting minutes for three months from January, March and April 2018. Overall, these were well attended by staff from a number of

disciplines, including obstetricians, anaesthetists and midwifery staff. This demonstrated staff interacted effectively and held useful discussions concerning incidents and the most recent never event, patient experience, complaints and compliments.

- The governance team displayed weekly safety alerts across the unit to highlight incident themes and learning from incidents. Staff confirmed the maternity governance teams and clinical effectiveness team supportive them regarding governance issues.
- Some staff were supported to conduct training in the root cause analysis methodology for incident investigation.
- We reviewed six team meeting minutes, two from each of the delivery suite, wards and community. The format of the team meeting minutes was not consistent and actions from the meeting were not always allocated to staff to be responsible for the actions. This had been previously highlighted in our 2017 inspection. However, a new standardised meeting template had been developed for recording maternity team meeting minutes and would be piloted in July 2018.

Managing risks, issues and performance

- The service used a local risk register to identify and monitor risk across the maternity service. This was in line with the trust's risk management policy. We reviewed the women and children's directorate risk register. The risk register was regularly reviewed and was discussed at monthly divisional risk meetings. Maternity risks on the risk register were escalated to the Board Assurance Framework (BAF) appropriately.
- We reviewed the maternity risk register as of June 2018, which had 28 risks recorded. The recorded risks were representative of what staff told us were their main concerns for the service, such as medical and midwifery staffing. Each risk had a review date and allocated risk owner. We saw evidence some risks had been reviewed and information updated accordingly. However, some risk review dates had expired and there was no indication of progress made. For example, the risk that identified caesarean section and induction of labour rates exceeded the national rates was due to be reviewed in December 2017.
- The risk register had not been updated following the in-depth review which had been planned. In addition, the lack of access to two compliant emergency operating theatres as recommended by the Safer

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Childbirth recommendations had been on the risk register since 2013. During this inspection we saw the building of a new purpose built second theatre at the end of the delivery suite was in progress however, this was not documented on the risk register.

- The risk register was discussed at the monthly maternity governance meetings. We reviewed minute meetings for January 2018, March 2018 and April 2018. The risk register was a standing agenda item. Risks were discussed in March 2018 and April 2018 meetings. There was attendance by consultant obstetricians, matrons and lead midwives at all meetings. The Divisional Director for Midwifery, Gynaecology and Sexual Health had not attended any meetings. The Deputy Director for Midwifery, Gynaecology and Sexual Health attended the April 2018 meeting only.
- It was noted in the April 2018 meeting that improvements to the risk register formatting were required to ensure actions were updated and completion dates recorded.
- We saw maternity risks were identified and reviewed via the trust's Board Assurance Framework.

Managing information

- The service used an electronic maternity records system together with paper-based patient records.
- A number of different electronic systems were used across the department which did not communicate directly with one another. This could prevent certain aspects of patient information being available to all staff and staff may not be fully updated regarding a patient's care and treatment.
- Community midwives had electronic tablets to use in the community setting. Access to all systems could be problematic depending on the remote internet access however; staff informed us this had improved.
- Following our inspection, we requested a large amount of data about the maternity service from the trust with tight timescales in which to provide this to us. The service could provide all of the required information in a suitable format and in a timely way.
- The service had routinely provided weekly and monthly data regarding the concerns we raised in the warning notice we issued in September 2017.

Public engagement

- The maternity service supported a multidisciplinary forum 'Walsall Maternity Voices Partnership' which met

quarterly. The aim of the forum was to involve parents and stakeholder representatives in the development and improvement of the maternity services at the trust. In addition, ensuring maternity services met the needs of the local population was also a priority for the forum.

- The service was involved in 'whose shoes workshops' which provided opportunities for staff to engage with pregnant women and parents to improve the maternity service.
- The maternity department was piloting the use of tablets for collating Friends and Family Test feedback with the aim of increasing the response rate.
- The maternity service supported an awareness event relating to female genital mutilation (FGM) which included signposting pregnant women who had experienced FGM to specialist FGM clinics held at the trust.
- We saw from the board papers for June 2018 meeting, a patient experience was included regarding care in maternity (and the neonatal unit). A patient who had given birth prematurely at the unit in March 2018 and her partner attended to present their experience of the department. They stated: "the care and consideration of staff had been fantastic on the maternity ward." It was a scary time for the parents but staff instilled confidence. "Staff were helpful, friendly, thorough and coherent with clear explanation given." This recognised an improvement in patient experience on the maternity unit. Work had been undertaken in the midwifery department to improve staff communication with patients.

Staff engagement

- The CEO held a 'trust connect' engagement event which included key themes and discussions regarding the trust value updates.
- The recent 2017 staff survey results had shown improvements of maternity staff engagement and working with autonomy.
- Leaders of the maternity service held monthly meetings to celebrate success.
- Staff told us they felt more valued and appreciated by the trust and maternity service leaders, which was an improvement from our last inspection.
- The community staff held a community forum each month which was used to implement change and drive improvement.

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- The service had implemented an employee of the month award scheme in August 2017 to recognise staff contribution to the service. However, not all staff we spoke with were aware of this award scheme.
- The service celebrated international day of the midwife in May 2018 with a number of different events held on the unit.
- On the wards, the ward manager thanked all staff personally to recognise their contribution to the department.
- A staff engagement lead worked across the trust in September 2017. They conducted a number of focus groups in maternity to collate staff feedback which was then shared with the senior team.
- Senior staff held an event for staff to come and tell them their opinion of what it was like to work in the department. The aim was to make staff feel engaged with the changes being implemented in maternity. This included problem solving exercises events and pizza. Changes were made as a result for example, reducing elective caesareans when there were planned caesareans.
- Some staff were under the impression there had been an increase in staff investigations and suspensions which was impacting on staff morale.
- Leaders of the service planned ahead to ensure sustainability of the service. However, improvements in the sustainability of the service and in particular improved staffing levels in the hospital setting had been partly achieved by having a birth cap in place and closing the midwifery led unit. We had concerns that the service may not be sustainable if the unit was delivering to its capped level and the midwifery led unit re-opened.
- The transitional care service had been nominated for a network award for transitional care.
- Service leaders were implementing measures to assist in the delivery of mental health care for the department. The service was implementing a perinatal mental health team for the service.
- The trust had recently implemented a quality improvement faculty which encompassed the Listening into Action Programme and the service improvement team. The faculty aimed to support staff with improving their services. The first phase focussed on human factors training for maternity staff held in April 2018.
- An enhanced recovery process for patients following caesarean sections was commencing in the next few months to enable a quicker recovery.
- The maternity service was part of a 'Big Baby' trial conducted in collaboration with a university and another hospital trust. The purpose of the trial was to determine if starting labour at 38 weeks for patients whose babies appeared to be bigger than expected reduced the risk of shoulder dystocia.
- The service had an agreement with a local specialist women's trust for provision of an obstetric and gynaecology consultant advisory support service since October 2017. A consultant had supported the service particularly regarding obstetric leadership.

Innovation, improvement and sustainability

- Staff in the maternity department were motivated and engaged with driving improvement for the service. This was an improvement from the previous inspection. We discussed the pace of improvements which needed to be maintained and increased and changes needed to be sustained and nurtured. The service appeared to be on an improvement journey and senior staff were now actively accepting and addressing the problems identified.

Outstanding practice and areas for improvement

Outstanding practice

- Funding had been secured for 170 midwives to conduct Phi learning. This learning is endorsed and supported by the Royal College of Midwives.
- The transitional care service was an innovative and dedicated approach to postnatal care.

Areas for improvement

Action the hospital **MUST** take to improve

The trust was placed in special measures by the Secretary of State for Health in February 2016 following our announced comprehensive inspection in September 2015.

- Ensure information in different languages, picture formats and cue cards was available to patients.
- Ensure access was available to the translation phone line and patient privacy was protected.

Action the hospital **SHOULD** take to improve

- Ensure all staff complete mandatory training as required for their role.
- Ensure gases are stored with the required signage on the doors.
- Ensure vaccination provision is sufficient to protect women and their babies.
- Ensure regular infant abduction exercises are conducted in the department to check for any gaps in the process and assess staff awareness of their role.
- Ensure processes are in place to store breast milk safely.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not ensure information was accessible in different languages, picture formats and cue cards. The use of the translation phone service was variable and did not always protect patient privacy.