North Bristol NHS Trust

Southmead Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Southmead Hospital

Good 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Southmead Hospital.

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

Southmead Hospital provides maternity services to the population of Bristol, North Somerset and South Gloucester.

Maternity services include an early pregnancy unit, maternal and fetal medicine, antenatal clinic including sonography, day assessment unit and triage, antenatal ward (Quantock), central delivery suite including high dependency rooms, midwifery led birthing centre (Mendip Birth Centre), 3 maternity theatres, postnatal ward (Percy Phillips), transitional care ward (Mendip), an ultrasound department and community midwifery services. Between April 2022 and March 2023, 5,485 babies were born at Southmead Hospital.

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

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

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

- Our rating of good for maternity services did not change ratings for the hospital overall. We rated maternity services as good in safe and well-led.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited all areas of maternity services including antenatal and sonography department, day assessment unit and triage, antenatal ward (Quantock), central delivery suite, midwifery led birthing centre (Mendip Birth Centre), maternity theatres, postnatal ward (Percy Phillips Ward), obstetric high dependency area and the transitional postnatal care ward (Mendip Ward).

We spoke with 29 midwives, 3 support workers, 6 doctors, senior leaders, the maternity and neonatal voices partnership and 10 women and birthing people. We received 533 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 9 patient care records, 6 observation and escalation charts and 4 medicines records.

Our findings

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Maternity

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect woman and birthing people from abuse, and managed safety well.
- The environment in most areas was suitable, and the service had enough equipment to keep women and birthing people and their babies safe.
- The service mostly had enough midwifery and medical staff, planned and actual staffing numbers were equal to each other.
- Staff assessed risks to woman and birthing people, acted on them and kept good care records. They mostly managed medicines well.
- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of woman and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with woman and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Not all medical staff had received the relevant training on recognising and reporting abuse.
- The service did not always control infection risk well, not all areas were visibly clean.
- The environment in the day assessment and triage unit was not suitable, but the service had plans to address this.
- Not all staff received an annual appraisal.
- On inspection, we found staff did not always store all medicines and prescribing documents safely. However, the service took immediate action to address this.
- The service did not always report all incidents to external bodies, such as the national learning and reporting system.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Leaders revised the training competency framework in line with the NHS England Core Competency Framework version 2 standards and this was fully aligned to national strategies. The framework included (but was not limited to) modules for the most recent 'Saving Babies Lives Care Bundle' diabetes in pregnancy, fetal monitoring and surveillance, obstetric emergencies, equality, equity and personalised care, care during labour and neonatal basic life support.

Leaders linked training needs to lessons learned from incidents, national requirements and the voices of women and pregnant people. The practice development and facilitator midwives were within the continuous improvement and learning team (CILT) alongside audit and governance midwives. This ensured training reflected learning from outcomes and incidents.

Most midwifery and nursing staff received and kept up to date with their mandatory training. Local leaders kept a record of training compliance. Records showed that in October 2023 88% of midwives had completed their mandatory midwifery study day. However, we did not see data for the trust-wide aspect of mandatory training which included, infection prevention control, fire safety and information governance.

The mandatory training was comprehensive and met the needs of woman and birthing people and staff. Service leaders developed an annual training needs analysis. In addition to trust-wide mandatory training, 4 Practice Development Midwives (PDM) ran a specialty maternity training programme for maternity staff. Also, 4 practice facilitators supported training throughout the unit. Training was aligned to the national framework for the provision of maternity services and reflected the saving babies lives care bundle v3. For example, staff received fetal wellbeing training, infant feeding training and multi-professional obstetric skills and drills training.

Staff received training to monitor fetal wellbeing throughout pregnancy and during labour. The service provided a full fetal wellbeing day, which required staff to review current national guidance, on intermittent and continuous fetal monitoring during labour, the saving babies lives care bundle and case discussions. Records for November 2023 showed that 94% of consultants and midwives had completed the training, and 85% of other medical staff had completed the training. After the training staff had to complete a competency test and achieve an 85% pass rate. Practice educators offered staff that did not meet the target additional support to make sure they achieved the requirement.

The service made sure that staff received multi-professional simulated obstetric emergency training. This training was attended by anaesthetists, doctors, midwives, and maternity support workers. Education staff created simulated scenarios based on the previous year's incidents. This year the training focused on hypoglycaemia, shoulder dystocia and eclamptic seizures. Records showed that from January to November 2023 training compliance was 94% for midwives 94% for obstetric consultants and 82% for other doctors. Compliance for maternity care assistants was 80%. Service records showed that industrial action had influenced training compliance figures.

Staff working on or rotating onto the midwifery led unit undertook 6 monthly skills and drills evacuation of the pool training. In addition, all labour ward coordinators were trained in evacuation from a pool and a coordinator was available on every shift. All new starters received pool evacuation training as part of their induction.

Safeguarding

Maternity

Staff understood how to protect woman and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The service provided data for the whole Women and Childrens division which included neonatal and paediatric staff. National Safeguarding Children intercollegiate guidelines state that 'all staff involved in planning care for people should receive level 3 safeguarding training'. Records showed that 95% of midwives and nurses had completed level 3 safeguarding children and adults training.

Following our inspection, the service provided evidence that 100% of consultants and 68% of doctors in training had completed relevant level 3 safeguarding training. They told us there were no occasions when a doctor in training would have full responsibility for a woman or birthing person without the safety net of other colleagues with the relevant expertise. However, records showed that medical staff compliance was 61% for safeguarding level 3. Therefore, we were not assured that medical staff had the knowledge and skills to recognise abuse or neglect or make the appropriate referrals.

Staff could give examples of how to protect woman and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Midwifery staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked woman and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified woman and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed the baby abduction policy and undertook baby abduction drills. Service leaders completed a baby abduction structured debrief following a simulated baby abduction exercise. Risks and areas of improvement were identified. The exercise highlighted areas for improvement. For example, the need for additional bleeps for key staff, that security needed to be more vigilant regarding 'tailgating' (when somebody shadows another person to exit without being seen). Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity

Most maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

At our last inspection, we found staff did not always follow safe systems to provide assurance of the cleanliness of ward furnishings and fixtures. During this inspection, the inspection team found that though overall the unit was clean, some areas of the Percy Phillips ward were dusty. The service told us there were building works outside the ward which may have impacted. We reviewed cleaning records and saw the ward met cleaning standards in the 3 months prior to the inspection. The team found some toilets and bathrooms were stained or had not been cleaned in line with cleaning schedule.

The service generally performed well for cleanliness. All matrons oversaw infection prevention and control (IPC) in maternity. In addition, the service had recruited an IPC midwife for 8 hours a week. Service leaders produced quarterly infection control reports which showed that data was gathered every month for hand hygiene, intravenous care, ventilator bundles, central venous lines, and cleaning standards data. Records showed that the trust set a target of over 95% compliance. The September 2023 report showed that most areas achieved this and that over the year September 2022 to September 2023 there had been marked improvements with staff compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits.

We saw staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed ‘bare below the elbows’ guidance. Data showed that performance for hand hygiene mostly over 95%.. From December 2022 to August 2023 records showed that 4 cases of Meticillin-sensitive Staphylococcus Aureus (MSSA) were reported, which were community acquired infections.

Staff cleaned equipment after contact with women and birthing people. Staff used green ‘I am clean’ stickers to show equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The maternity unit was fully secure with a monitored entry and exit system and security presence 24 hours every day. During our inspection, we raised concerns that once within the unit people could access most areas, except central delivery suite. This meant there was a risk the public access areas they did not need to be in. Leaders provided evidence of steps taken to ensure security within the unit, including risk assessments of the estate, the maternity security policy, daily contact with the estates department and regular baby abduction drills, with clear action plans and debriefs for staff.

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

However, the design of the environment did not reflect national guidance in all areas. This was because service provision had increased, and the service had outgrown the space. For example, triage and day assessment unit were in the same area. They lacked a private room to safely risk assess in confidence or place women and birthing people with

transferable infections. Leaders acknowledged difficulties with the current estate and described plans to reconfigure and upgrade the estate, including plans to move day assessment unit (scheduled care) into a different area to separate it from triage. Estates issues were on the risk register for the service and subject to regular review and scrutiny by leaders. Following our inspection, the service told us plans to move the day assessment unit to another area separate from triage had been completed.

Staff carried out daily safety checks of specialist equipment. Records showed that staff used an equipment checklist when completing equipment checks. Resuscitaires were checked daily in each room on central delivery suite. However, we saw some minor gaps in checks of adult resuscitation and emergency trolleys throughout the unit.

Matrons completed monthly environmental and patient care audits to ensure that staff completed important safety tasks. The audit captured data for different aspects of care. For example, security and fire procedures, safe staffing, patient identification bracelets for newborns, tap flushing, cleaning schedules, orientation records for new staff and temperature checks on fridges. Matrons used the data to identify areas for improvement and fed these back to staff at handovers and via newsletters.

During the inspection, staff on the central delivery suite were unclear on the cleaning process for the birthing pool. We escalated this to managers who provided evidence that a standard operating procedure was in place for use of the birthing pools and signs in each room with a pool outlining the correct cleaning procedure. The service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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

The service complete ligature risk assessments for each area of maternity to identify and reduce the risk of self-harm by vulnerable patients and records confirmed this.

However, we found that the fridge used to store milk on the Perry Phillips ward had not been calibrated within safe timeframes, also fridge temperature checks had not been completed for 15 occasions in one month.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff used national tools to assess and monitor women and birthing people during the antenatal period.

Staff risk assessed women and birthing people at their booking appointment (first full risk assessment at the beginning of pregnancy) and used the five elements of the ‘Saving Babies Lives Care Bundle version 3.

Maternity

The service ran a pre-term antenatal clinic for women and birthing people identified as being at risk of pre-term labour. Clinical staff monitored fetal wellbeing and growth. Women and pregnant people were given advice and leaflets on monitoring fetal movements during pregnancy and fetal growth was monitored via antenatal appointments and routine antenatal growth scans.

Audit data captured during records audits for 10 sets of patient records showed compliance with carbon monoxide monitoring was 100%. This is important as exposure to carbon monoxide is especially dangerous during pregnancy because it deprives the baby of oxygen, slows its growth and development, and increases the risk of miscarriage, stillbirth and sudden infant death.

Staff used a nationally recognised tool, the Modified Early Obstetric Warning Score (MEOWS), to identify women and birthing people at risk of deterioration and escalated them appropriately. We reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Matrons audited a small number of records (3) each month to check that staff had used MEOWS and escalated appropriately at the time of the audit. Audits for July to September 2023 scored 100%. However, the total records reviewed for the time frame was 9 and the audit did not just focus on MEOWS but on other aspects of care as well.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Leaders recently introduced (August 2023) a standardised risk assessment tool for staff working in triage with a focus on the rapid triage of women and pregnant people. The aim was to make sure that all women were risk assessed by an appropriately trained midwife on arrival to triage. Staff used a standardised RAG (colour coded) tool to identify immediate and high-risk patients. Formal training had been given to all midwives including staff working in the area to ensure practice was embedded.

However, the service did not have a consultant or registrar doctor allocated to triage to review women and birthing people. This was a potential risk as middle grade doctors may not have the experience to identify all medical conditions or deviations from normal during pregnancy. Some staff told us this had led to delays in medical reviews as the doctor may take longer or need to seek support from a senior doctor. Leaders had recognised this risk and recruitment was underway for consultants to provide further support and cover for triage. Following our inspection, the service provide information to show medial staffing was in line with Royal College of Obstetricians and Gynaecologists guidance for units with the number of births at Southmead Hospital.

Leaders monitored waiting times to make sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. The service used experienced midwives to answer triage calls to ensure the safe assessment of women and people. The telephone line was based in its own office and used specialised telephone call software. All calls were recorded on the patient record staff. The service monitored telephone calls received by triage staff and records showed that from June to October 2023 staff answered 5787 telephone calls.

The maternity triage waiting times for review audit was at an early phase of implementation, as it had recently been changed due to implementation of a new triage model. Records showed that the service had monitored attendances, reason for attendance, the initial categorisation by a midwife and the number of women and birthing people seen within 15 minutes of arrival. The data was collected monthly from June to October 2023 and showed there had been 5,121 attendances to triage. During the audit quarter, the service implemented a new patient record system in September which meant there were gaps in data. For October 2023 the data showed that 59% of women and people were seen within 15 minutes by 2 midwives per shift. Records also showed that those women who were rated immediate risk received ongoing care 85% of the time in September 2023.

Maternity

There was no data for how long it took for a medical review once risk had been identified. Managers told us they were aware of the need to monitor this but had been unable to do so yet as the model was only recently implemented. However, they had plans to monitor this going forward.

Service leaders monitored and reported induction of labour delays every 2 weeks in line with NHS England definitions and requirements. The service told us they had no delays in initiation of induction of labour since national reporting started. In addition to national reporting, the service monitored delays in induction of labour once the process had started monthly to support continuous improvement work. Data from May to October 2023 showed that on average 49% of inductions were delayed for 18 hours or more and 39% of inductions were delayed for more than 24 hours. The impact of delays on maternal wellbeing is anxiety, longer stays away from home and longer labours. However, the service had a process to plan inductions of labour and ensure these were reviewed and prioritised by a multidisciplinary team. There was a quality improvement programme in place and the service was contributing to a regional working group to identify and improve the induction of labour pathway.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used evidence-based tools such as partograms to monitor progress in labour and used a standardised format for monitoring fetal wellbeing which included a fresh eyes approach to carry out fetal monitoring safely and effectively. A partogram is a record of observations in labour to provide a pictorial overview of labour, and to alert midwives and obstetricians to deviations in maternal or fetal well-being and labour progress. Leaders monitored compliance to ensure women and birthing people who were having continuous cardiotocograph (CTG) monitoring were safely assessed throughout childbirth. Records from June to September 2023 showed clear interpretation and management plans following CTG in 100% of cases and staff did 'fresh eyes' at each hourly assessment in 85% of cases.

Midwives used a process to manage 3rd and 4th degree perineal trauma caused during childbirth. Maternity dashboard data from April to August 2023 showed that leaders had set a target of 3.3% of all vaginal births. However, during the period this was only achieved one month out of 4. The average rate was 4.1%.

The service had recently recruited a recovery nurse to recover women and pregnant people after they had a caesarean section under general anaesthetic. Out of hours this care was provided by a recovery nurse from the theatres team and there were plans to increase the number of recovery nurses specifically for maternity services. Midwives also received annual training from anaesthetic staff and an anaesthetist was available 24/7. Theatre staff followed the World Health Organisation (WHO) safer surgery checklist when admitting and discharging patients from the area. Managers monitored compliance to completing the checklist and records from July to September 2023 showed 100% compliance.

A multidisciplinary team of doctors and midwives reviewed patients who required high dependency care. Women who required mechanical support for breathing would be cared for on the intensive care unit. The service had funded several midwives to complete 'care of the critically ill women' at the local university.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Leaders completed monthly records audit on 10 sets of patient records. Data from April to August 2023 showed that 100% of midwives completed a mental health risk assessment at booking and 80% completed a further assessment at 36 weeks of pregnancy.

Maternity

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used the SBAR (Situation, Background, Assessment and Risk) tool to handover individual patient care. Each episode of care was recorded by health professionals and was used to share information between care givers. Managers monitored compliance to completing the tool and records from August to October 2023 showed that most areas performed well scoring 90 to 100%.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

The service provided transitional care for babies who required additional care. Staff caring for babies having transitional care used a Neonatal Early Warning Risk Assessment (NEWT) tool to record observations and feeding. Leaders completed an audit in October 2023 of 10 sets of records which showed 100% compliance to using the tool correctly.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Midwives monitored planned discharges via a white board in the staffing area of the ward so that they had oversight of the workload. Women and pregnant people received a physical and emotional risk assessment before discharge and were given the contact details of emergency services and third-party organisations, like the health visitor, the GP and local infant feeding groups. Women with additional mental health needs were signposted to additional services or discharge by a multi-professional team.

Midwifery Staffing

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

The service mostly had enough nursing and midwifery staff to keep women and babies safe. The service last completed a staffing and acuity review in July 2022. It said the service did not have enough staff to meet the planned needs of women and birthing people. There was a shortfall of 22.33 whole time equivalent (WTE) clinical staff bands 3-7 and 5.15 WTE specialist midwives. A business case was submitted to trust leaders to ask for funding for an 21% uplift for the midwifery workforce which the board approved in November 2022.

Following our inspection, the service provided information that showed recruitment was ongoing and they were now fully compliant with the acuity review recommended funded establishment.

Leaders told us midwifery staffing had been a challenge, but they had recruited and planned to have no vacancies by February 2024, if all recruited midwives started in post. The trust had temporarily paused intrapartum services at Cossham Hospital, in order to maintain safe staffing levels at Southmead Hospital.

Maternity

The number of midwives and healthcare assistants usually matched the planned numbers. We looked at planned versus actual staffing in the maternity departments for April to September 2023. We found on central delivery suite the fill rate (percentage of staff planned against actual staffing) for midwives was 92.7% in September 2023, with the lowest full rate in June 2023 at 85.4% The fill rate in September 2023 was 91.8% on Quantock ward and 93% on Percy Phillips ward.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. The service did not provide data on all red flags reported but did provide data to show the number of incidents raised in relation to safe staffing, unfilled bank shifts, compliance with one-to-one care in labour and supernumerary status of the labour ward coordinator. This showed in September 2023 the number of unfilled bank shifts had fallen from previous months, there were 24 incidents reported, one to one care in labour was achieved 100% of the time and the labour ward coordinator was supernumerary 100% of the time.

There was a dedicated team of flow midwives 24 hours a day, 7 days a week, who had oversight of the staffing, acuity, and capacity and a supernumerary shift co-ordinator on duty around the clock.

Managers adjusted staffing levels daily according to the needs of woman and birthing people. Managers moved staff according to the number of woman and birthing people in clinical areas. We attended the daily 'flow meeting' and saw all areas of the maternity department were represented and staff moved to meet the clinical needs of women and birthing people, as well as to support discharge from the unit.

The service had high vacancy rates, turnover rates, and use of bank nurses. The current vacancy rate for band 5 & 6 midwives was 23.9 WTE. The service was committed to retaining the current workforce and had developed a retention plan to support new starters, support a work life balance and improve career development. They used incentives such as starting all newly qualified midwives at band 6 to improve recruitment and retention. The midwifery 'Pipeline' update for September 2023 showed the service expected 6.96 WTE midwives to start in November 2023 and a further 12 WTE to start in February 2024, all newly qualified. A further 3 international midwives had started and a further 3 were expected in December 2023 but were recruited as band 4 midwives to gain the required UK competencies. This meant skill mix was a challenge with a lot of inexperienced staff, meaning experienced midwives would have to support them and students as well as perform their normal duties. However, the service ensured additional support was available from the divisional management team and senior midwives and practice education facilitators were placed in areas where there were a higher proportion of new midwives.

Managers requested bank staff familiar with the service and made sure all bank staff had a full induction and understood the service.

The service made sure staff were competent for their roles. However, managers did not always have time to appraise staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through annual appraisals. Data showed an overall appraisal rate of 60% for midwives, with only 57% of band 6 midwives having received an appraisal. However, following our inspection, the service provided information that showed in December 2023 77.3% of midwives had received an annual appraisal and

plans were in place to ensure all had received this by the end of March 2024. Three practice development lead midwives, based within the continuous improvement and learning team supported midwives. Appraisals are important as they provide the opportunity to acknowledge the work staff have done and offer encouragement for them to strive to high levels of achievement as well as manage their performance.

Managers made sure staff received any specialist training for their role. For example, the trust funded courses at a local university for midwives who wanted to become professional midwifery advocates.

Practice development midwives developed a Maternity Hotspots Programme, which was part of the specialist maternity training programme. The aim was to focus on one area of need for one month to make sure practice was embedded. Data showed that each month there were different themes for example in July 2023 there was a focus on antenatal screening, in September 2023 there was a focus on the new patient record system. The programme was run throughout the year.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had 18 obstetric consultants, 21 registrars, and 13 senior house officers working at the unit. Records showed that all consultants had clear job plans which included time for their specialist roles and their working week was clearly documented. On central delivery suite there were 80 hours a week of consultant obstetric presence with resident consultant Monday to Friday 8am to 9pm and weekends 8am to 2pm and 7.30pm to 9pm. The service always had a consultant on call during evenings and weekends. Out of hours there was a non-resident consultant dedicated to obstetrics. The service had no incidents when a consultant did not attend a 'must attend' clinical situation between April and September 2023.

The service had low vacancy and turnover rates for medical staff. However, the service had seen significant use of locum doctors between July and October 2023 due to sickness absence and industrial action. Managers could not always access locums when they needed additional medical staff, with the fill rate of locum doctors below consultant grade at 47%. When this happened, consultants acted in those roles to maintain safe medical staffing.

The service had plans to increase the medical workforce and had plans in place to ensure safe staffing during each doctors' industrial action. Recruitment was ongoing including clinical fellow roles and an additional 2 obstetric consultant posts. Leaders told us they were thinking of new ways to address gaps in the middle grade rota such as training advanced care practitioners or physician associates.

Managers made sure locums had a full induction to the service before they started work. The service created standard operating procedures for short term locums and long-term locums.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. However, the triage service was covered by a senior house officer (SHO), staff told us they could sometimes lead to delays in medical assessment as they may need to access further support from senior doctors.. Staff told us they would call the consultant if they needed additional advice. Leaders had recognised these issues and were recruiting and additional 2 consultants to improve cover in these areas.

Maternity

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

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust had recently adopted a recognised maternity patient record system. Prior to the system going live service managers completed monthly records audits which looked at 21 aspects of care, for example, recording safeguarding, mental health, plotting fetal growth, CO monitoring, blood results and infant feeding assessments. Data collected from April to August 2023 showed that most of the time records were well maintained. However, there were gaps in August regarding recording of fetal growth and there were gaps over the whole period for CO monitoring at 36 weeks. Outcomes were fed back to staff via handovers, and staff updates.

We reviewed 9 paper records and found records were clear and complete.

Records were stored securely. All computers were password protected and staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Woman and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 4 prescription charts and found staff had correctly completed them.

Managers gave staff a medicines management and intravenous therapy assessment to complete to ensure staff safely administered medication. The service used a skills and competency matrix to identify the relevant elements of medicines management, skills and competency required for each grade. However, the service did not provide data on how many staff had completed competency testing.

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

The service did not have dedicated pharmacy support and was the only service within the division not to do so. Leaders had recognised this was a risk and this risk was monitored through the risk register. The service had submitted a business case to the trust for funding for specialist maternity services pharmacist.

Staff did not always store all medicines and prescribing documents safely. Inspectors found that there was no lock on the clinical room where the post-partum haemorrhage emergency trolley was stored, which contained some medicines. This was because the secure card access was broken, staff told us this had been reported. We found several out-of-date medicines on the ward and Central Delivery Suite (CDS). Some emergency drugs were left out of the fridge longer than

manufacturers recommendations or not labelled. Also, the administration card found in the emergency grab bag which included magnesium sulphate was unclear and difficult to read. During the inspection we fed back our concerns to service leaders, who immediately rectified our concerns. The service provided evidence of initial actions taken and to ensure ongoing compliance. This included increased reviews and checks of medicines, labelling of emergency medicines taken from the fridge to show length of time 'out of fridge', correcting the labelling of magnesium sulphate, and providing additional training for staff.

Incidents

The service mostly managed safety incidents well. Most staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave woman and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored. However, we were not assured incidents were always recorded.

Most staff knew what incidents to report and most knew how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Most staff could describe what incidents were reportable and how to use the electronic reporting system. Staff we spoke with gave examples of incidents they had reported, and feedback received following this. They told us learning from incidents was shared by email and newsletters. We saw themes and learning from incidents were shared at handovers and safety briefings. However, some staff told us they were unsure how to report incidents using the online incident reporting system.

Staff could give examples of themes from incidents and actions taken to address them. There was evidence that changes had been made following feedback. For example, staff told us a theme had been seen with an increase in readmission rates due to baby weight loss. The infant feeding team provided additional training to staff, and this was reduced.

The service had no 'never' events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The trust was an early adopter of the Patient Safety Incident Response Framework (PSIRF). PSIRF is the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The trust had a patient safety incident response plan which included elements specific to maternity services and set out how the service would respond to patient safety incidents over the next 18 months. The service used a blended approach to gaining data and insight into incidents including electronic incident reports by staff, complaints and feedback and intelligence from external partners.

The service had a continuous improvement and learning team (CILT) made of up midwives, patient safety and quality improvement practitioners. The CILT team reviewed all incidents reported by staff as moderate harm or above with senior midwives reviewing and managing all other incidents. Incidents that were moderate or above, that met maternity and neonatal safety investigation programme (MNSI) criteria, or which staff had raised concerns over were reviewed at the weekly multidisciplinary 'insight' meeting, regardless of level of harm. . Any incidents requiring escalation were reviewed at a weekly executive review group meeting and a patient safety incident investigation was commissioned where appropriate.

Maternity

Managers investigated incidents thoroughly. They involved woman and birthing people and their families in these investigations. The CILT team included a patient experience midwife who helped to review incidents from the perspective of women and birthing people and their families. Leaders gave examples of incidents which had been identified through complaints and feedback and progressed to a patient safety incident investigation.

The service had 1 serious incident in the last 12 months, which related to a retained foreign object. The service had investigated this incident and it did not meet the criteria for a never event. We saw the service had carried out a patient safety incident investigation and implemented changes as result of learning.

The service had a monthly postpartum haemorrhage (PPH) forum, where all PPH over 1000ml and a selection of lower loss PPH were reviewed to look at what went wrong if anything, what went well and what could be learnt from how the PPH was managed. This was attended by members of the wider multidisciplinary team including the blood bank and blood conservation team.

Records showed that the CILT team had oversight of outstanding incident reviews. There were 12 incidents that were under investigation for over 60 days, with one ongoing investigation at 223 since the reporting date.

Managers reviewed incidents potentially related to health inequalities. The hospital served a diverse population and leaders understood the challenges and risks associated with different ethnicities. Staff captured ethnicity during booking assessments and incident reviews.

Staff understood the duty of candour. They were open and transparent and gave woman and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of woman and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of woman and birthing people. Women, birthing people and their families were invited to multidisciplinary team ‘after action reviews’ to look at the outcomes from investigations and the service had received positive feedback from the woman and staff involved in this process.

Managers debriefed and supported staff after any serious incident. Staff could access psychology support following any incident and the trust promoted psychological safety for staff reporting and involved in incidents.

Service leaders implemented the perinatal quality surveillance matrix (PQSM) in response to national reports. This showed outcomes for various aspects of care and included perinatal and maternal mortality and the number of incidents graded moderate and above. Data from April to September 2023 showed that there had been 6 neonatal deaths under 6 days of birth and one maternal death and a total of 89 women and people who had required high dependency care. The reported incidents of moderate harm and above only showed 5 incidents had been reported. Leaders told us incidents would still be reported to the national reporting and learning system (NRLS) but may not be graded as moderate or above if no gaps in care were identified.

However, we were not assured all potential patient safety events were reported to NRLS. This was because we reviewed NRLS for October 2022 to May 2023 and saw 13 incidents of PPH reported, but the maternity dashboard showed 15 PPHs over 1500ml in May 2023 alone.

Maternity

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for woman and birthing people and staff. They mostly supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The service was part of the women's and children's division and was led by a divisional operations director, divisional director of midwifery and nursing and clinical director. The triumvirate were supported through clear professional arrangements, with 2 deputy divisional directors of midwifery and nursing and obstetric governance and speciality lead consultants. There was a continuous improvement and learning team which acted as governance group for maternity services.

Leaders were visible in the service for woman and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The maternity leadership team had been strengthened in the last 18 months and gaps in roles filled. Staff told us this had led to increased stability and leadership support.

Maternity safety champions and non-executive directors supported service leaders to monitor safety and outcomes. The service had 1 executive and 1 non-executive maternity safety champion. Both were highly visible in the service and demonstrated a strong understanding of the challenges and opportunities maternity services faced. They ensured maternity services were strongly represented at board level and acted as advocates for the service. Staff we spoke with knew who the safety champions were and told us they often visited the service. The executive team visited wards on a weekly basis and staff spoke of how accessible and encouraging they were. The executive safety champion worked proactively to understand the needs of the service, for example by undertaking training in the new triage system alongside maternity staff.

Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. Leaders were undertaking the NHS England perinatal leadership programme to update and improve their leadership skills.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders were working with a neighbouring NHS trust to develop a collaborative vision across the whole of Bristol and had held workshops with key staff and stakeholders to develop a strategy for a single-managed perinatal service across Bristol. This aligned with the trust clinical strategy for 2023 to 2028.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The aim of the strategy for a single-managed perinatal service was to enable resources to be used collaboratively to provide the best maternity care and outcomes possible. The service planned to create shared standards across both trusts so variation in care standards was only when necessary due to clinical need. The service had already aligned digital systems such as the maternity patient record system and had a digital strategy in place.

Service leaders had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for woman and birthing people and babies. Staff described a clear purpose to provide the best possible care for women, birthing people, babies and families.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and implemented all relevant recommendations. These were carried forward into the vision and strategy for the service. The vision for a single-managed perinatal service took account of the national context and reflected the key actions from both Ockenden reports and the NHS 3 Year Delivery Plan for Maternity and Neonatal Services'.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of woman and birthing people receiving care. The service provided opportunities for career development. The service had an open culture where woman and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff told us local leaders and mangers were approachable and teams worked well together. They told us they felt the midwifery voices was now well represented due to improved stability in the leadership team.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Staff were proud to be the 'home of PROMPT training' and focused on providing safe care to women, birthing people and babies.

Leaders understood how health inequalities affected treatment and outcomes for woman and birthing people and babies from ethnic minority and disadvantaged groups in their local population. The clinical strategy for the service was designed to address health inequalities across Bristol.

Leaders monitored outcomes and investigated data to identify when ethnicity or deprivation had an impact upon treatment and outcomes, which they shared with teams to help improve care. They gave examples of how reviews of patient safety incident investigations had examined health inequalities and mandatory maternity training had been amended to address this. For example, by ensuring training included scenarios for women and birthing people where English was not their first language.

Maternity

The service had a lead consultant obstetrician for equality and diversity who had examined outcomes reported nationally for still birth and neonatal deaths and looked for themes around health inequalities. This had led to project work with specific communities to break down barriers and improve outcomes for them.

Leaders recognised the need to improve how they promoted equality and diversity in daily work. The Workforce Race Equality Standard is a set of measures which enable NHS organisations to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. The latest WRES results for staff from all other ethnic groups were notably different to results for white staff, indicating poorer experiences for staff from all other ethnic groups. However, this data was trust wide and not specific to maternity services. Staff we spoke with told us they worked in a fair and inclusive environment. Leaders described plans to improve the diversity of the maternity workforce using sponsorship models for midwives from non-White communities.

The service provided opportunities for career development. Leaders and managers supported staff by working clinically to release staff to attend development opportunities. They offered staff places on the Healthcare Excellence in Leadership and Management (HELM) programme and places at a local university to become professional midwifery advocates.

The service had an open culture where woman and birthing people, their families and staff could raise concerns without fear. Leaders told us they felt it was important to actively engage with staff as response rates to the NHS staff survey were low. The service had taken part in the national NHSE health and wellbeing support with a visit in March 2023. We reviewed the feedback report which noted good wellbeing services including wellbeing support from the retention midwife.

The service had several initiatives to improve staff experience including listening events, an open-door policy, wellbeing champions, therapy dogs, additional annual leave and free parking and staff counselling services. They had an award programme where staff could be nominated and recognised by the trust for positive work. Staff could access support from a trust Freedom to Speak Up Guardian.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in woman and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. The service had a patient experience lead within the continuous improvement and learning team. As well as dealing with complaints they worked closely with the Maternity and Neonatal Voices Partnership (MNVP) to ensure all relevant feedback was received and concerns dealt with. Between August and October 2023, the service received 6 formal and informal complaints, 2 required no action, 1 was upheld and the remaining complaints were being investigated.

Governance

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

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The divisional management board met monthly and included representatives from obstetrics and midwifery as well as business managers. We reviewed minutes of the last 2 meetings and saw they covered all expected areas of business and were action oriented.

Quality and performance data was reviewed monthly at the perinatal governance meeting and then at the divisional quality governance meeting. The perinatal quality surveillance matrix was then reported monthly to the trust board as part of the integrated performance report. Each quarter the trust quality committee carried out a deep dive into this data.. We reviewed the last 3 reports and saw they covered expected quality and outcome data such as admissions to neonatal unit, perinatal mortality, incidents graded moderate or above, incidents reported to healthcare safety investigation branch (HSIB), workforce, risk register and compliance with the maternity incentive scheme.

Leaders met the trust executive team monthly at divisional review meetings.

All stillbirths and neonatal deaths were reviewed by a multidisciplinary team at monthly perinatal mortality meeting using the national perinatal mortality review tool.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Each area had regular forums and there was a weekly 'Insight' meeting to look at all incidents and learning from maternity services. Relevant incidents from the Insight meeting were reported to the monthly perinatal governance meeting. Representatives from maternity services sat on the trust patient safety clinical risk committee to share learning from maternity trust wide and ensure learning from elsewhere in the trust was shared to staff in maternity services.

Managers used a '5 way' system to ensure key messages were shared with staff. This included emails, newsletters, daily safety briefing, posters with QR codes to access reports and messages and 'tea trolley' training. Tea trolley training was short training or key messages delivered on the wards or units during breaks.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service had a lead midwife for clinical documentation who monitored policy review dates on a tracker and reviewed policies and guidance to make sure they were up to date. There was a process to ensure that they were alerted of national changes to guidance or practice. There was monthly maternity documentation group with representatives from across the multidisciplinary team to review and ratify policies and guidance.

Management of risk, issues, and performance

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

Maternity

The service participated in relevant national clinical audits. Outcomes for women and birthing people were mostly positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve woman and birthing people's outcomes.

The service provided data to the national Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) survey. We reviewed the MBRRACE-UK perinatal mortality report for 2021 births and saw the stabilised and adjusted extended perinatal mortality rate was 5.04 per 1,000 births, which is lower than the average for similar trusts. The service reviewed the data and presented a report to the divisional quality governance meetings, outlining related improvement workstreams to improve performance further, especially in relation to outcomes for women, birthing people and babies whose ethnicity was non-White.

We reviewed Clinical Quality Improvement Metrics (CQIMS) for the service, which are a set of metrics derived from the Maternity Services Dataset for the purpose of identifying areas that may require local clinical quality improvement. The service was in line with national averages for outcomes such as postpartum haemorrhage, vaginal birth following a caesarean section and babies born pre-term. However, results for the number of women having a third or fourth degree tear at delivery were higher than the national average and in the upper 25% of all organisations.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. In year 4 (published May 2023) the service had not met 3 out of the 10 safety actions, midwifery workforce, compliance with Saving Babies Lives and multidisciplinary training. The service had developed action plans to address the areas of non-compliance and leaders told us they were on track to meet all 10 requirements for year 5. The continuous improvement and learning team tracked current compliance with the safety actions and reported these through governance structures. We saw they provided evidence of progression towards compliance to the trust quality committee in October 2023 and highlighted where there was a risk compliance may not be achieved.

The service had a visit from NHS England and NHS Improvement in August 2022 to provide assurance against the 7 immediate and essential actions from the first Ockenden report. We looked at the outcomes of the visit and saw the service was compliant with all the immediate and essential actions but still needed to improve compliance with multidisciplinary training.

The service monitored compliance with the saving babies lives care bundle v3. We saw they had completed relevant audits to check their compliance and ensure they provided safe care.

The service had a service specific quality dashboard to maintain oversight of the entirety of the care provided to women. During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators and provided target figures to achieve. The dashboard reported on clinical outcomes such as maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (preterm delivery, admission to neonatal unit), public health information and statistical analysis. It showed performance each month and year on year, as well as against target. The dashboard showed the overall rate of third and fourth degree tears had improved from the pervious year and unplanned admission to neonatal intensive care was below the trust target.

The service monitored indicators that contributed to health inequalities, for example during perinatal mortality reviews ethnicity and socioeconomic status was examined to see if there were any contributory factors or trends related to particular communities.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a local audit programme driven by improvement identified through incidents and dashboard data. This was led by the continuous improvement and learning team and they audited performance and identified where improvements were needed. For example, local audits had included areas such as VTE risk assessment completion and the offer of anti-coagulants which were non-porcine based. This is positive practice as it addresses health inequalities faced by women and birthing people who cannot have porcine products for religious reasons. The audit programme clearly aligned with relevant national audits and indicators and each audit had a clinical lead assigned to it.

The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. There were twice weekly quality huddles attended by divisional and local managers to look at information from the quality dashboard and local audits.

Maternity leaders had made changes to the maternity dashboard so that it was aligned to the regional dashboard which was being developed by the South West Strategic Clinical Network. The dashboard used monitoring techniques designed to show normal and abnormal variations in outcomes.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through several channels including the incident management system and staff feedback. Risks were reviewed by local managers and the continuous improvement and learning team then escalated. The service had a local risk register which was reviewed monthly at the divisional quality governance meeting. It was also reviewed by the trust low level risk management group, who approved all risks to be escalated to trust level.

We reviewed the risk register and saw the top risks aligned with those outlined by leaders and managers and staff we spoke with. We saw risks were reviewed regularly and actions recorded, they had a local risk owner assigned and an executive sponsor. All risks had some controls in place which were outlined in the risk register.

Information Management

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

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see year on year performance for comparison. The service's dashboard had statistical process control (SPC) which was used to interpret the data presented. SPC uses statistics to identify patterns and anomalies and helps to distinguish changes which need to be investigated from normal variation in data points. This meant service leaders could interpret the data and knew when there was an issue that needed investigation.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. There was a learning board on the central delivery suite which gave staff at glance information on performance and improvement work such as management of postpartum haemorrhage. The service used ‘laser posters’ with QR codes which were displayed across the unit to share information about improvement work and performance. For example, we saw a poster which gave a brief outline of changes staff should make following a healthcare safety investigation branch (HSIB) report in relation to baby cooling with a QR code link to the full report for staff to read.

The information systems were integrated and secure**.** Computers were password protected and staff logged out of computers when they were not in use.

Data or notifications were consistently submitted to external organisations as required. We saw notification of relevant incidents was made to HSIB.

Engagement

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

The maternity safety champions were part of the Acute Provider Collaborative (ACP) board with the neighbouring NHS trust to progress plans for a single perinatal service across Bristol. The ACP board had formed in 2021 and the service was working in partnership with the neighbouring trust to develop a joint clinical strategy.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The chair of the MNVP met monthly with managers and attended the monthly safety champion walk rounds and meetings. The MNVP reported a positive working relationship with the service and told us they could contact managers and leaders to raise concerns. The MNVP had co-produced information with the service such as videos they produced and posters for display within specific communities.

The patient experience team worked closely with the MNVP but also recognised this was a limited resource. The service, therefore, employed 'patient partner' volunteers – women and birthing people with lived experience who volunteered to help make changes and improvements in the service. For example, patient partners were supporting the service to improve the maternity service's website to make it easier to navigate for women, birthing people and their families.

The service made available interpreting services for women and birthing people and collected data on ethnicity. Leaders had audited the top languages used by women and birthing people when booking maternity care and the number of times translators were required. They used this data to target the translation of posters and information for the local community. The trust had an interpreting and translation policy and a procedure to provide guidance to staff on how to communicate with women and birthing people whose first language was not spoken English and ensure the use of professional interpreting and translation services.

Leaders understood the needs of the local population. Staff had set up 'Project Smile' in partnership with local charities and the Islamic Centre to address poorer outcomes identified through MBRRACE data. Staff engaged with women and birthing people through focus groups, with each session ending with a quick quality improvement idea and ideas for a bigger project. Examples of quality improvement included signs on doors of birthing rooms to prevent women and birthing people being interrupted during prayer and silk hair bonnets made available for women and birthing people staying on the unit. The service was working with Bristol Muslim Strategic voices to identify alternative anti-coagulants as the most used medicines include porcine derivatives.

The service was working with Black Mothers Matter and the learning programme was supported by midwives from the service. The service provided video discharge information tailored to women and birthing people whose first language was not English. This included a storyboard where women and birthing people could choose a different language and explained what to expect post discharge.

The service had a lead obstetrician for bereavement and equality and diversity. They worked in partnership with the local council and were part of the council inequalities group. This group had identified maternal mortality as the race equality project for the year and this improved the service's connections to key people and community groups.

The service worked proactively with the local prison to ensure it met the needs of pregnant and birthing women and people who resided there. Complex care midwives developed 'separation boxes' specific to needs of women and birthing people who resided in local prison with some of the contents tailored to be suitable to return to prison with the women. The service had worked with the prison catering department to ensure pregnant women and birthing people received more nutritious meals. Staff had taken part in unexpected birth in prison scenario training and changes had been made by the prison service following this.

We received 533 responses to our give feedback on care posters which were in place during the inspection. Of these 281 were positive, 209 gave mixed feedback with some positive elements and 43 described negative experiences. The majority of women and birthing people gave positive feedback about care given during labour and caesarean section and praised the caring and compassionate attitude of staff. However, themes from negative feedback included poor experience of care on the postnatal ward, lack of infant feeding support, a lack of support to get food or drinks and the impact of short staffing on some staff's attitudes, timely pain relief and call bells being answered.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. The service had a continuous improvement and learning team (CILT) which was a multidisciplinary team made up of specialist midwives, patient safety and quality improvement practitioners. It included external standards such as saving babies lives and maternity incentive scheme, practice development, audit, risk and governance, patient safety and incidents, perinatal mortality and bereavement support. This ensured continuous learning and improvement was embedded and shared across different aspects of maternity services. For example, following an incident, staff led an improvement project to develop a new pathway for identifying head trauma in neonatal babies. The implementation of the new pathway was led by practice development midwives who had been involved in the quality improvement project.

The CILT team maintained a register of quality improvement projects across the service which tracked their progress and ensured project leads and senior leadership support was allocated to each project. We saw the service had a number of quality improvement projects including supported decision making in induction of labour and monitoring room temperatures at birth to improve outcomes for neonatal babies.

The service used Patient First as a quality improvement methodology. This is a recognised and proven system for delivering significant long-term change within the NHS, which identifies key areas for improvements and the root cause of problems. It provides tools, techniques and a standard approach to identifying and tracking improvement needed.

Maternity

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. The service was part of the Preventing Caesarean Birth Surgical Site Infection (PreCiSSIon) collaborative to reduce surgical site infections following caesarean birth in all acute maternity units in the West of England region and had implemented the PreCiSSIon care bundle.

Outstanding practice

We found the following areas of outstanding practice:

- The service used 'patient partner' volunteers, women and birthing people with experience of using maternity services to provide the perspective of someone using the service and help to make changes and improvements.
- Staff had set up 'Project Smile' in partnership with local charities and the Islamic Centre to address poorer outcomes identified through MBRRACE data. Staff engaged with women and birthing people through focus groups, with each session ending with a quick quality improvement idea and ideas for a bigger project.
- The service worked proactively with the local prison to ensure it met the needs of pregnant and birthing women and people who resided there. Complex care midwives developed 'separation boxes' specific to needs of women and birthing people who resided in local prison with some of the contents tailored to be suitable to return to prison with the women.
- The service had a continuous improvement and learning team which was a multidisciplinary team made up of specialist midwives, patient safety and quality improvement practitioners. This ensured continuous learning and improvement was embedded and shared across different aspects of maternity services.

Areas for improvement

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

Action the trust SHOULD take to improve:

- The service should ensure that it improves safeguarding training compliance for medical staff, especially doctors in training.
- The service should ensure that all areas are visibly clean, and cleaning takes place on Percy Phillips ward in line with cleaning schedules.
- The service should ensure all staff complete daily checks of emergency equipment.
- The service should ensure fridges used for storage of items other than medicines are maintained in line with manufacturers guidance and temperatures are checked daily.
- The service should ensure that triage wait times audits include data for wait times for a medical review so the service has full oversight.
- The service should ensure that it continues to maintain the safe storage and monitoring of medication throughout the unit.

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- The service should ensure the occurrence of medical ward rounds is recorded using an appropriate audit tool.
- The service should ensure that potential patient safety events are reported to external systems such as the Learning from Patient Safety Events or National Reporting and Learning System.
- The service should act to reduce the number of women experiencing third and fourth degree tears at birth.
- The service should continue to make improvements to the induction of labour process, to minimise delays to women and birthing people once the induction of labour has started.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 4 other CQC inspectors and 4 specialist advisors including a consultant obstetrician and midwives. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.