Care Quality Commission

Birmingham Women's NHS Foundation Trust

Birmingham Women's 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

Overall rating for this hospital	Requires improvement
Maternity (community services)	Good
Maternity (inpatient services)	Outstanding
Surgery (gynaecology) and Termination of Pregnancy	Requires improvement
Neonatal services	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Birmingham Women's Hospital provides a range of health care services to women and families across the West Midlands and further afield which include gynaecology, maternity and neonatal care, as well as a comprehensive genetics service. On average, the trust looks after 50,000 patients a year and carries out over 3000 operations. The trust also supports home births to women in South Birmingham.

The trust employs around 1582 staff, 119 medical, 550 nursing and 913 are from other disciplines. The hospital has 210 beds, 117 provided from maternity inpatient services, 53 from neonatal intensive care, this includes a transitional care ward, intensive care unit, high dependency unit, special care baby unit and 42 from gynaecology services.

We carried out an announced inspection visit from 12 to 14 April 2016 and two unannounced visits on 15 and 27 April 2016. This inspection was part of our comprehensive inspection programme.

We held focus groups with a range of staff in the hospital, including consultants, midwives, nurses, junior doctors, student midwives and nurses, administrative and clerical staff, pharmacists, domestic staff and porters. We also spoke with staff individually.

We inspected and reported the Termination of Pregnancy services (ToPS) under Surgery and Gynaecology services because the volume of ToPS activity did not warrant an individual report. For the same reason, aspects of end of life care for women and babies was inspected and reported under Surgery and Gynaecology and neonatal services.

Overall, we rated this trust as requires improvement. We found that safety and caring was good and effective, responsive and well led required improvement.

The senior team was visible and accessible to staff and managers were seen as supportive and approachable. Managers were keen to engage and include staff in service development. There were some concerns raised in relation to the Termination of Pregnancy service, however the trust had commissioned an external review to look at issues raised.

There was a positive and enthusiastic culture throughout the hospital. Staff were committed and passionate about their work and proud of the services they offered to patients. Staff were keen to learn and continuously improve and patients were very positive about the care and treatment they received at the hospital.

Our key findings were as follows:

Safe

- Generally, there were sufficient numbers of consultants and middle grade doctors to provide good quality care and treatment for patients in line with the Royal College of Obstetricians and Gynaecologists guidance. However, in Maternity Inpatients from January 2014 to June 2015 there was 90-120 hours coverage per week which was below the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations of 168 hours for the number of births.
- There were established systems for reporting incidents and 'near misses'. Staff had received training and were confident in using of the incident reporting system.
- The latest national reporting and learning system (NRLS) data showed the trust reported 1,468 incidents to NRLS from January 2015 to January 2016. 96% were no harm or low harm (70% no harm). 33% of incidents took 31 to 60 days to report, with 23% taking more than 90 days to report. The Obstetrics specialty had the most incidents reported (838), accounting for 57% of all incidents. Gynaecology accounted for 18% and Neonatology for 17% of all incidents.

Summary of findings

- There were no cases of hospital acquired infections for example; **Methicillin-resistant Staphylococcus aureus** MRSA), Meticillin-Sensitive Staphylococcus Aureus (MSSA)or Clostridium difficile (C.diff) reported from December 2014 to December 2015.
- There was a visibly high standard of cleanliness throughout the hospital. Staff were aware of current infection prevention and control guidelines and observed good practice.
- All relevant staff had received appropriate levels of training for safeguarding children and safeguarding of vulnerable adults, supported by robust policies and procedures. The trust set a target of 100% for safeguarding children training level 1, and they achieved this. For level two, they set a target of 85% and they achieved 97%. For level three, the target was 85% and they achieved 87%. For adult safeguarding, level one the trust achieved 100% against a target of 85% and for level two the trust achieved 97%.
- There were challenges to fill sonography vacancies in the outpatient department which resulted in long waiting times, in some cases in excess of five hours. Across the four maternity community teams there was a vacancy rate of 5.93%, although the recruitment programme was underway, the trust found it challenging to recruit community midwives.
- Neonatal staffing levels could not meet the national standards of nurse to patient ratio. However, neonatal staff were working extra hours to fill in gaps on the staffing rota which ensured care and treatment was delivered in a timely manner.

Effective

- There were challenges around appropriate fasting times for women awaiting surgery, in some cases women had been starved pre-operatively in excess of 12 hours which could have impacted on their recovery. Time without fluids was at least five hours which is longer than the two hours which the Royal College of Anaesthetists recommends.
- People were given a choice of suitable and nutritious food and drink, and we observed hot and cold drinks available throughout the day. Women who accessed the birth centre used 'smoothie' making equipment to help meet their nutrition and hydration needs whilst in labour.
- Patient's religious, cultural and dietary needs were considered and food was provided in accordance with their requirements.
- Women were supported to feed their babies using their preferred method. The trust had been awarded UNICEF Baby Friendly Initiative (BFI) stage three accreditation. BFI focuses on staff knowledge and skills to support families with their infant feeding choices.
- The trust acknowledged that poor breastfeeding support had resulted in an increase of neonatal readmissions due to related feeding issues. This had been raised as a CQC outlier. The service had developed an action plan to address these issues. The action plan was comprehensive and we saw target completion dates were on track to be achieved.
- Nine extra support staff had recently been recruited and trained to offer breastfeeding support in an attempt to improve skin to skin contact for new-born babies and improve breastfeeding initiation rates.
- The hospital's 2016 Patient Led Assessment of the Care Environment audit identified a score of 96.76% for ward food.

Caring

- People were respected and valued as individuals and empowered as partners in their care across all services.
- Women and their families were treated with dignity and respect and we saw outstanding caring attitude and particularly within Inpatient Maternity services.

Summary of findings

- Feedback from people who use the service, and those who are close to them was continually positive about the way staff treated people.
- People told us staff went the extra mile in supporting women and provided continued help and advice to women who wanted to breast-feed.
- Staff took people's personal, cultural, social and religious needs into account and actively engaged with people to provide cultural sensitive care and treatment at every given opportunity.
- People's emotional and social needs were highly valued by staff and embedded in their care and treatment.

Responsive

- There had been a long standing issue with the time taken to assemble an on-call second theatre team to perform emergency caesareans. This had been unresolved and on the risk register for more than five years. During this time audits had been completed and the case made for a second resident team, however, the divisional leadership team had been unable to secure agreement from the trust to take this forward.
- We noted the information on medical terminations of pregnancy did not include the risk of a late gestation foetus showing 'signs of life' and the potential requirement to register with the coroner.
- Bookings for pregnancy and birth at the trust were limited to ensure demand did not exceed capacity.
- Bed occupancy for 2014/2015 was between 64% and 72%, however for 2015/2016 the bed occupancy ranged between 72% and 82% and both years were higher than the national average.
- Within neonatal services bed capacity leads worked six days a week to organise patient transfers and admissions. The unit did not close to patients in need of admission however, at times the unit would delay ex-utero (babies already born) transfers until cots were vacant and staffing levels were appropriate.
- BWH provided a neonatal transport service for babies to and from the West Midlands area. This did not include a baby stabilisation service. There were procedures in place should a babies condition deteriorate in transit. A comprehensive neonatal team of 16 trained staff were responsible for the transport service.

Well led

- The trust had not captured through audit the risk to breach of its condition of registration of ToP services under the Health and Social Care Act.
- There were challenges around governance arrangements and risk management with termination of pregnancy service. For example, the new contract for the termination of pregnancy service had commenced in January 2015. At the time of the inspection training for staff had not been formalised despite concerns expressed by staff about the need for clarity regarding actions to be taken.
- The concerns we raised in relation to infection prevention and control, and the management of medicines and intravenous fluids within surgery services had not been identified in the audits undertaken within the service.
- We observed a very good relationship between clinical staff and NICU managerial staff. The unit managers described a good relationship with the executive managers.
- Generally there was a culture of openness, flexibility and willingness was demonstrated amongst all the teams and staff we met.

We saw several areas of outstanding practice including:

- Video books were available for women who did not speak or read English which meant women had access to information about the service and their care and treatment.

Summary of findings

- The trust was awarded a s (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service.
- Gynaecology services had been successful in becoming an accredited British Gynaecology Endoscopy (BSGE) centre for complex endometriosis.
- A five year contract for providing complex abortion care had been secured. This contract covered Walsall, Wolverhampton, Sandwell and West Birmingham and South Birmingham.
- The bereavement service had developed an integrated care pathway for bereaved parents which ensured consistency in formation provided and had been developed to reflect the needs of patients and their families.
- The neonatal intensive care unit introduced the routine use of pulse oximetry for all babies within 24 hours of birth or prior to discharge. This has been identified as significant in the early detection of critical congenital heart defects prior to the deterioration of the baby.
- The outpatient gynaecology department provided fast rehydration to patients seen in the hyperemesis clinic resulting in a reduction in re-admissions and overnight stays.

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

Importantly, the trust must:

- Ensure Healthy Start vitamins are stored securely in all community maternity team offices.
- Medicines are prescribed in line with the trust policy.
- All community midwives must attend safeguarding supervision in line with Department of Health requirements (Working Together to Safeguard Children, 2015).
- Ensure the safe storage of medicines including intravenous fluids.
- Improve the application of infection prevention and control procedures in relation to the use of personal protective clothing and equipment and hand hygiene.
- Properly maintain all equipment and medical devices.
- Provide secure storage for patient records across all clinical areas.
- Ensure the project to develop a second emergency theatre team is progressed in a timely manner.
- The trust must ensure all HSA1 certificates for termination of pregnancy are fully completed by the registered medical practitioners signing them.
- Identify, monitor and mitigate all risks relating to developing the complex abortion service pathway. In particular, in respect of processes required and the impact on staff and patients of distressing elements of late gestation termination.
- Provide training to ward staff caring for complex abortion services patients in the appropriate procedures for responding to late gestation termination of pregnancy where the foetus may be indicating signs of life.
- Ensure team work between the complex abortion care service, ward teams and bereavement team and wider medical teams are strengthened to mitigate risks involved in late gestation termination of pregnancy.
- Take steps to ensure multi-disciplinary team work is improved where clinicians from other trusts are contributing the care of patients.

Summary of findings

- Clarify the method clinician's should use to establish consent to termination of pregnancy from adult patients with learning disabilities.
- Ensure the data collected for the Neonatal Audit Programme (NNAP) reflects the care given within the unit.
- Ensure staff receive mental capacity training in line with trust guidance.
- Implement a system to assess, monitor and improve the waiting times across clinics in the outpatients and diagnostic departments.
- Mitigate the risks relating to the health, safety and welfare of service users by regularly reviewing the risk register and include a timescale in completing any risks identified.
- The trust must reduce the waiting times in the diagnostics department by having sufficient numbers of qualified staff.

In addition the trust should:

- Review community midwives' caseloads to ensure equitable distribution of numbers and complexity pending review of staffing planned for June 2016.
- Review how patients are informed about and supported to clearly understand the process and all potential clinical elements of late gestation termination of pregnancy.
- Develop and put in place agreed after care pathways for ward staff to follow to best support patients. These should address the needs of patients where they may differ in respect of the decision to terminate their pregnancy.
- Review the procedures for pre-operative fasting to ensure food and fluids are withdrawn for the minimum length of time to ensure the safety of patients and the maintenance of hydration.
- Ensure where best interest decisions are made on behalf of a patient that reasons for the decision and other options considered, are clearly recorded.
- Review the application of its policy for the use of interpreters to ensure all patients who require an interpreter are offered an independent interpreter.
- Ensure there are processes in place to ensure learning is shared between different parts of the service and there is improved communication across services to enable the development of best practice.
- Review the process for escalation of clinical concerns to ensure a timely response is achieved.
- Introduce measures to reduce or remove risks on the risk register within a timescale that reflects the level of risk and impact on people using the service.
- Take steps to improve the accessibility and reliability of the electronic care planning system in place in gynaecology.
- Consider the perception that gynaecology is not dealt with fairly and issues prioritised in the same way as for other services and take steps to ensure equity.
- MEWS charts are completed appropriately.
- Patients undergoing induction of labour are supported to continue the induction process within a satisfactory timeframe.
- On-site consultant hours reflect the recommendations by the RCOG in relation to the number of births.
- Use the capacity data captured to influence staffing levels and business plans.

Summary of findings

- Consider it provides the persons with the information they would reasonably need by giving patients leaflets about their post treatment, rather than being directed to go onto the website.
- Consider it has a consistent system across all departments to flag up any learning disability patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity (inpatient services)	Outstanding ☆	Overall we rated this service as 'outstanding'. Staff provided an excellent service to women and their babies. Incident reporting and learning from incidents was timely. All clinical areas were visibly clean and well maintained. There were cleaning schedules in place and levels of cleanliness were audited regularly. Medicines and medical gases were stored appropriately. Medical records were completed and stored securely and accessed without delay 24 hours a day. There were effective processes for safeguarding mothers and babies, despite staff shortages in midwifery, recruitment plans were in place to increase staffing numbers. Incorrect prescribing of medicine for reducing the risk of venous thromboembolism was a challenge for the trust, however this had been identified and addressed. Evidence based care and treatment was provided and audited appropriately. Pain relief options were available to women and patient outcomes were monitored effectively using a maternity dashboard system. Targets for breastfeeding initiation rates were achieved and there was a detailed action plan to address the neonatal readmission outlier. Staff were supported with education and training to achieve competences in practice. We observed excellent multidisciplinary team work and staff had a good understanding of the Mental Capacity Act 2005. Staff genuinely respected and valued people as individuals and empowered them as partners in their care. There was overwhelming positive feedback from women and their families. Patients' emotional, social, cultural and religious needs were highly valued by staff and were embedded in their care and treatment. There were excellent arrangements to support individuals with complex needs, through access to clinical specialists and medical expertise.

Summary of findings

Bookings for pregnancy and birth at the trust were capped to ensure demand did not exceed capacity and there was a robust high activity escalation policy.
Complaints and concerns were included on a performance dashboard and regularly monitored to improve the care and treatment for women and their babies.
The maternity service had a clear vision for the future was embedded in the culture of the service and staff were clear of the governance and management structure within the service.
There was a clear management structure, which included strong clinical engagement. Local leadership within the directorate was visible, approachable and supportive. Staff were actively encouraged to follow specialist interests within the service and constantly strived to improve care and treatment.
Managers actively sought public opinion about service development and improvement, and innovation was supported and encouraged within the service.
During our inspection a serious incident occurred. Family members were supported by the HOM personally and a robust package of debriefing, discussion and counselling was put in place. We observed support provided to staff following the event. Senior staff exhibited behaviour above and beyond expectation to ensure staff were supported in every way possible.

Maternity (community services)

Good

Overall we rated this service as good. There was good incident reporting systems and learning from incidents embedded across all four community teams and the home birth team.
Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. Record keeping was consistent and equipment was available, clean and tested at regular intervals.
Medicines were prescribed, administered and stored in line with the trust policy. Each team had a safeguarding champion and arrangements were in place to safeguard adults and babies from abuse and harm.

Summary of findings

			The ratio of community midwives to women was 1:120, which is above the recommended average of 1:96. Mandatory training was well attended and appraisal rates were 95%. Patients and their relatives spoke highly of the care they received in the community maternity service. The community team leaders were not represented at directorate meetings. The teams demonstrated varying levels of effective leadership. There were good examples of effective strategic leadership however there were areas where local leadership required improvement. Risks were reviewed on a regular basis, however there was limited audit of service provision and patient feedback. Patients and their relatives spoke highly of the care they received in the community maternity service.
Surgery (gynaecology) and Termination of Pregnancy	**Requires improvement**		We found surgical services (gynaecology) and termination of pregnancy services overall required improvement. Staff were kind and professional and attentive to patients' needs. Patients felt informed and involved in their care and decisions about their care. However we had concerns about the standards of infection prevention and control and the servicing and maintenance of equipment. The checking and storage of medicines, intravenous fluids and consumables required improvement. Care and treatment was mostly based on evidence based guidance but we found food and fluids were withheld for unnecessarily long periods prior to surgery. Training and professional development of staff were generally good but there had been a lack of training and preparation of staff for some physical and emotional aspects of late terminations of complex pregnancy. The fact that some members of the multi-disciplinary team were not directly employed by the trust reduced flexibility and affected the timely access to some aspects of care.

Summary of findings

Services were planned and delivered to meet the needs of the local population and there was evidence of the service working with local commissioners to improve access for patients. However, we noted variations in the flow of patients, which had a potential impact on the efficient use of resources and the ability to respond to the individual needs/preferences of patients.
Local leadership within gynaecology was good, however, the priority given to gynaecology within the wider trust was perceived to be low. As a result there were challenges in moving forward with developments and addressing risks.
The governance framework had been strengthened and progress was being made in addressing the long standing issues. However, the trust had not captured through audit the risk to breach of its condition of registration of the termination of pregnancy services under the Health and Social Care Act or the issues we found in relation to infection prevention and medicines management.

Neonatal services — Good

Overall we rated neonatal services as good. Staff reported incidents, and lessons learned were shared with staff.
Nursing and medical staffing did not meet the national standards for neonatal unit staffing. The establishment of nurses were not sufficient to provide 1:1 care for the number of intensive care babies. However, the service worked towards meeting this target through a robust recruitment programme and staff backfilled vacancies to ensure babies received timely care and treatment.
Staff were aware of their responsibilities in regard to safeguarding. The unit was clean and provided an appropriate environment for caring for all levels of intensive care babies.
Care was evidence based and in line with good practice. Multidisciplinary working was good throughout the unit and parent involvement was encouraged. The unit did not meet the Neonatal Audit Programme (NNAP) standards due to inconsistent data entry.

Summary of findings

Training within the unit was incorporated into daily activity. Staff were caring and considerate to both the needs of the baby and the wider family. Some members of the management team within the neonatal unit were newly appointed or held interim posts.
The responsibility for management of risks were not always clear. Staff collected capacity data, but this was not acted upon.
The culture of the service was a supportive one with staff working flexibly to provide care.
Staff were proud to work for the service. This was reflected by the many compliments parents gave around the care their babies received.

Outpatients and diagnostic imaging

Requires improvement

We rated outpatient department and diagnostic imaging as requires improvement. Staff had a good understanding of the incident reporting process. Learning was shared and staff gave examples of changes in practice in response to reported incidents.
Staff provided a caring and compassionate service to patients. All communal and clinical areas were visibly clean with cleaning schedules in place. Records were completed and stored securely. Medication was stored appropriately and resuscitation equipment was checked daily and ready for use.
However, there were poor pathways in the antenatal clinic resulting in excessive waits for patients up to five hours. The excessive waiting times in antenatal clinic was not on the risk register and there was no monitoring system in place to assess the waiting times within clinics. Clinics often ran over and staff worked above their contracted hours to manage clinics. In some cases women were given two appointments for the morning and afternoon which meant a double journey which could have been avoided if the pathway was more effective.
Nursing staffing levels were generally good, however, there were unfilled sonographer vacancies within the diagnostic imaging department which contributed to the long waiting times across outpatients.

Summary of findings

Staff followed the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS), when making decisions about patients with disabilities and mental health issues.
Staff had effective supervision, appraisals were up to date and staff were encouraged to continue to update their professional development. 84% of staff attended mandatory training against a target of 85%.
There was clear leadership in both the outpatients and diagnostic imaging services. Staff felt supported by their local leaders who were visible on the departments and provided an open door policy.
There were examples of innovative practice in both the outpatients and diagnostic imaging services. Staff were proud of the hyperemesis unit, acute 'one stop' gynaecology clinic, home birth team pilot and the e-learning package.

Birmingham Women's Hospital

Detailed findings

Services we looked at
Maternity (inpatient services), Maternity (community services), Surgery (gynaecology) and Termination of Pregnancy, Outpatients & Diagnostic imaging, Neonatal services

Detailed findings

Contents

Background to Birmingham Women's Hospital

Birmingham Women's Hospital is the sole hospital site operated by Birmingham Women's Hospital Foundation Trust which serves more than 50,000 patients a year and carries out over 3000 operations. The trust also supports home births to women in South Birmingham.

The hospital is a major obstetrics, gynaecology and neonatology research hospital, one of only two specialist women's hospital trusts in England. The hospital has 210 beds, 117 provided from maternity inpatient services, 53 from neonatal intensive care, this includes transitional care ward, intensive care unit, high dependency unit, special care baby unit and 42 from gynaecology services. The trust provides community maternity care from four designated teams and also from a home birth team.

The trust is subject of a planned acquisition by Birmingham Children's Hospital Foundation Trust (BCHFT) The aim is to merge both hospitals into one organisation by 2017 and to "develop a shared vision to become the best women's and children's healthcare built around the whole family".

It is envisaged that the newly formed joint trust will be one organisation by January 2017. It is expected that both hospitals will continue to operate from their respective sites at the current time.

This inspection was part of our comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott retired NHS Trust Director of Nursing and Midwifery - Nottingham University Hospitals NHS Trust.

Head of Hospital Inspections: Tim Cooper - Care Quality Commission

The team included an Inspection Manager, eleven CQC inspectors and a variety of specialists including; an obstetrician and gynaecology consultant; neonatal consultant, senior radiographer, director of operations, deputy medical director, supervisor of midwifes, acute and community midwives, paediatric nurse and adult and children's safeguarding lead.

Detailed findings

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?

Before visiting, we reviewed a range of information we held about Birmingham Women's NHS Foundation Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We attended two patient focus groups; The Urogynae Patient Focus Group on the 7 April 2016 and also the Family and Patient Advisory Focus Group on the 12 April 2016 people shared their views and experiences of Birmingham Women's Hospital. Some people also shared their experiences by email or telephone.

The announced inspection of Birmingham Women's Hospital took place on 13 and 14 April 2016.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested and held a focus group with non-executive directors and trust governors.

We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We undertook an unannounced inspection of Birmingham Women's Hospital on 15 and 27 April 2016.

Facts and data about Birmingham Women's Hospital

Birmingham Women's Hospital is the main hospital site providing services as part of Birmingham Women's NHS Foundation Trust. There are 210 beds on the site, which comprises 117 from maternity inpatient services, 53 from neonatal intensive care, this includes transitional care ward, intensive care unit, high dependency unit, special care baby unit and 42 from gynaecology services. The trust employs around 1582 staff, 119 medical, 550 nursing and 913 are from other disciples.

The trust delivers a range of health care services to women and families across the West Midlands and the UK further which include gynaecology, maternity and neonatal care, as well as a comprehensive genetics service.

On average the trust looks after 50,000 patients a year, carries out over 3,000 operations and delivers 8,000 babies.

The health of the population in Birmingham is varied compared with the England average. Deprivation is higher than average and about 30% of children live in poverty. Life expectancy for women is lower than the England average.

Smoking related deaths and the under 75 mortality rates for cardiovascular and cancer are worse than the England average. Obesity in children and infant mortality are worse than the England average. For adults, obesity, alcohol related stays in hospital and recorded diabetes are all worse than the England average. Priorities in Birmingham include tackling childhood obesity, statutory homelessness, and reducing the numbers of vulnerable children and adults.

The trust has an annual income of around £97m and a current deficit of around £4.5m.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (inpatient services)	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity (community services)	Good	Not rated	Good	Good	Good	Good
Surgery (gynaecology)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Neonatal services	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Maternity (inpatient services)

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Outstanding
Overall	**Outstanding**

Information about the service

Maternity inpatient services were provided on a single site with approximately 8,000 deliveries each year. During our inspection, we visited the delivery suite, theatre suite, midwife-led unit, maternity assessment unit, antenatal ward, two postnatal wards, high risk induction suite, bereavement suite and the mortuary.

We observed care, looked at care and medicine records for 22 people and spoke with 17 patients and relatives and 38 members of staff across all disciplines.

Summary of findings

Overall, we rated this service as 'outstanding'. All staff were able to articulate how to report incidents and had done so in the past. There was clear evidence of learning from incidents, complaints and concerns.

All the clinical areas we inspected were visibly clean and well maintained.. Medicines and medical gases were stored appropriately and the service kept medical records securely in line with the data protection policy.

There were effective processes for safeguarding mothers and babies. We saw evidence of robust risk assessments and although there were staff shortages in midwifery, recruitment plans were in place to increase staffing numbers. Incorrect prescribing of medicine for reducing the risk of venous thromboembolism was a problem for the trust. There were recent examples of incorrect prescribing of medication which had been reported as a medication incident.

We saw evidence based care and treatment was provided and audited appropriately. Patient outcomes were monitored effectively using a maternity dashboard system.

Targets for breastfeeding initiation rates were achieved and there was a detailed action plan to address the neonatal readmission outlier. Staff were supported with education and training to achieve competencies in practice. Staff genuinely respected and valued people as individuals and empowered them as partners in their care. Feedback from people who used the service and

Maternity (inpatient services)

those who were close to them were positive about the way staff treated people. Patients' emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Maternity staff engaged with patients to identify what would make their hospital stay more comfortable. Complaints and concerns were included on a performance dashboard and regularly monitored; responses to complains were appropriate and actively engaged the patient in service improvement.

The maternity service had a clear vision for the future, 'driving patient experience and safety though a holistic family approach.' There was a clear management structure, which included strong clinical engagement.

Managers actively sought public opinion about service development and improvement, and innovation was supported and encouraged within the service.

During our inspection a serious incident occurred. Family members were supported by the HOM personally and a robust package of debriefing, discussion and counselling was put in place.

Are Maternity (inpatient services) safe?

Good

We rated this service as 'good' for safe because:

- All the staff we spoke with could explain how to report incidents and many told us they had done so in the past. There was very clear evidence of learning from incidents, complaints and concerns.
- The maternity safety thermometer allowed the team to review risks of harm and record the proportion of mothers who had experienced harm-free care.
- The clinical areas we inspected were visibly clean and well maintained. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- Medicines and medical gases were stored appropriately.
- The service kept medical records securely in line with the data protection policy. Midwives could obtain records easily when women arrived in labour out of hours.
- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children.
- We saw evidence of robust risk assessments.
- Despite staff shortages in midwifery, this did not impact on the positive experience of people who used the service and robust recruitment plans were in place to increase staffing numbers.

However we also saw that:

Incorrect prescribing of medicine for reducing the risk of venous thromboembolism was a problem for the trust. Recent examples of incorrect prescribing had been reported as medication incidents, actions had been put in place to mitigate future incidents and this was monitored appropriately.

Incidents

- All staff we spoke with knew how to report incidents via the trust's electronic incident reporting system.
- From October 2014 to September 2015 the service reported 22 serious incidents. Of these, 13 were unexpected admissions of neonates (a child less than four weeks old) to the neonatal intensive care unit. A

learning point that arose from the investigations into neonatal admissions was the misinterpretation of cardiotocograph (CTG) readings. Since the investigations, a national approach to CTG interpretation had been implemented in the department call 'fresh eyes' where midwives and doctors review each other's interpretations of the fetal heart rate readings hourly, to offer professional challenge of interpretation and the ongoing patient plan. Daily CTG teaching sessions using examples from patients that had been on the delivery suite in the previous 24 hours occurred each morning. They were led by a consultant and involved the multidisciplinary team.

- The trust had reported five maternal deaths in the last 27 months (the first was in February 2014 and the last in April 2016). An external review had been commissioned and was underway to review the trust's investigations into the deaths in order to identify areas to improve patient safety.
- Staff used the nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool to identify risks. The trust's electronic reporting system flagged incidents to clinicians and the executive team. This allowed senior leadership to question the clinical teams and review incidents to gather all relevant information. Staff told us they reported all incidents according to the Serious Incident Framework (NHS, March 2015).
- 'Never Events' are defined as 'serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.' The trust had reported one never event between October 2015 and September 2016. This involved a surgical swab that was left behind in a patient during treatment. We saw that an immediate response to this incident had taken place. A multi-professional root cause analysis had taken place following the robust investigation and it was supported by a detailed action plan which had been completed within the indicated dates. Managers had drawn up a detailed checklist for staff to countersign for swabs. The labour ward also had an approved plan in place to site a white board in each delivery room, similar to those used in operating theatres so that real time swab counts were conducted. There were also plans in place to introduce an innovative wristband system to identify patients with surgical swabs or packs deliberately left in situ while transferring patients to other departments. This extra safety measure would minimise the risk of swabs being left behind by mistake. Staff told us about these initiatives to prevent a recurrence. Senior management were aiming to implement this within one month.
- All staff were able to explain how to report incidents and we saw very clear evidence of learning from incidents, including changes to guidelines. Staff understood the different levels of harm, low, moderate and severe and knew when to escalate to senior staff. For example, because of an incident that had been reported, staff regularly risk assessed all patients waiting for transfer to the delivery suite for induction of labour to evaluate their changing needs.
- Actions were taken and learning was shared both internally within the inpatient service and across the wider midwifery service. For example, we saw documentation that learning from an incident regarding maternal sepsis (a severe infection occurring in pregnancy) had been shared with the community midwives.
- A matron with responsibility for incidents received details of all incident reports, reviewed them and decided what action was appropriate. The service had clear guidelines about which types of incidents required a detailed investigation, known as a 'root cause analysis.'
- Each inpatient area had an incident lead midwife who participated in or conducted investigations into incidents. This local incident leadership facilitated an open reporting culture.
- Staff were actively encouraged to report incidents. Student midwives and junior doctors said incidents and case reviews were discussed as part of their teaching.
- The staff notice board displayed information about feedback staff could expect to receive after reporting an incident. This was: an immediate, automatic response confirming the incident report had been received, an acknowledgement within 48 hours from the individual investigating the incident and detailed feedback within 10 working days. This clear feedback process encouraged staff to report incidents as they felt they were contributing to improving patient safety.
- Staff described feedback they had received and were able to tell us of changes made as a result of clinical incidents.
- A multidisciplinary risk group met weekly to discuss significant or high impact incidents. This meeting also

facilitated an overview of all incidents so that themes could be recognised. The group reviewed in a constructive learning format to strive for continual improvement.
- Perinatal and maternal mortality and morbidity meetings were held monthly, involving multidisciplinary team members (MDT). Minutes and lessons learned were shared widely across the service.
- At every shift handover on the delivery suite staff discussed the weekly 'safety brief.' This document communicated key safety message for the week, for example, the importance of clear and up to date documentation.
- The service also had a 'risky business' newsletter where key incidents and learning was communicated, this was distributed by email and displayed on notice boards.
- Monthly perinatal meetings, attended by obstetric and neonatal staff, monitored perinatal mortality and morbidity and reported quarterly to the trust mortality and morbidity steering group, chaired by the Medical Director.
- The service reported stillbirth and neonatal death to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) as required.
- We saw information displayed in staff areas describing how to 'whistle-blow' about safety concerns. Staff said they would feel confident in doing this; however they felt they could raise concerns openly without using the whistle-blower pathway.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days.
- Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. Staff described the process as being open and honest, apologising verbally and also in writing if the hospital was to blame and keeping an open dialogue with the patient or their representatives during an investigation. We saw evidence to support this process was well imbedded across services.

Safety Thermometer

- The maternity safety thermometer allowed the team to review risks of harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation of mother from baby and psychological safety. In addition, it identified those babies with an Apgar score (a method to quickly assess the health of the new-born) of less than seven at five minutes post-delivery and those babies who were admitted to a neonatal unit.
- We saw evidence that safety performance was captured and evaluated in a monthly report. Service managers monitored performance against national guidance, for example: midwifery staffing against the National Institute for Health and Care Excellence (NICE) guideline 'Safe midwifery staffing for maternity settings.'
- The inpatient wards had safety thermometer information displayed in public areas, the delivery suite office and educational resource room. We saw data displayed for the preceding three months (January, February and March).
- For example in March the number of patients who experience a postpartum haemorrhage was 9% which was the same as the national average. The number of patient experiencing 3rd or 4th degree tears in March was 2% which was the same as the national average.
- For the period March 2015 to February 2016, 74.4% of patients had received harm free care which was in line with the national average.

Cleanliness, infection control and hygiene

- The clinical areas we inspected were visibly clean and well maintained. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- The hospital had appropriate policies and procedures in place to manage infection prevention and control (IPC). An IPC policies and procedures file was accessible on the ward and in theatres. Staff were aware of and showed us the location of these policies.

- The cleaning monitoring audit between July and December 2015 showed compliance to be over 98%.
- Staff were aware of current infection prevention and control guidelines. They followed good hand hygiene practice in all the areas we visited.
- Hand hygiene audits for July, August and September 2015 demonstrated average compliance of 98% for each month, which was above the trusts 95% compliance target.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand-washing sinks and hand gels. Notices were displayed encouraging visitors to wash their hands and indicating the steps to wash hands effectively.
- All staff we saw were adhering to infection control guidelines of 'bare below the elbows' where the use of jewellery, watches or long sleeves is prohibited to reduce the risk of spread of infection.
- We saw appropriate staff and patient attire in theatre. Staff followed evidence based guidelines for decontamination of operating sites.
- When staff entered or left the operating theatres, they changed their clothing to minimise the risk of infection to patients.
- Patients who required urinary catheter insertion had their risk of infection minimised by having a clear plan for insertion, maintenance and removal of the catheter.
- The hospital's 2016 Patient Led Assessment of the Care Environment audit identified a score of 99.8% for cleanliness.
- Information provided by the hospital showed from 1 June 2014 to 31 July 2015 there had been no cases of MRSA, clostridium difficile, Escherichia coli or methicillin-susceptible staphylococcus aureus infections.
- During their surgical pre-assessment appointment, staff gave patients a questionnaire which formed a risk assessment for potential infections such as MRSA. If assessed to be at risk, patients were screened and were only admitted for surgery if no infection was identified. Patients with infections were offered suitable treatment and reassessment. This policy complied with the Department of Health 2014 guidelines.
- There were suitable arrangements for safe disposal of waste. Infected, clinical and domestic waste was segregated in colour-coded bags and managed appropriately. Sharps such as needles and blades were disposed of in approved receptacles.
- During our inspection, we observed one patient who was being barrier nursed. Barrier nursing is a set of stringent infection control techniques used in nursing to protect staff and to reduce the spread of infectious conditions. All applicable equipment was available in plentiful supply and the midwife caring for the patient had a detailed knowledge of barrier nursing. They were aware who the infection control lead was if they required assistance.

Environment and equipment

- We checked 26 items of equipment at random and found they were clean and fit for purpose.
- We saw records showing staff carried out daily checks of equipment such as the neonatal resuscitation equipment known as a 'Resusitare' and adult emergency trolleys. The hospital used a green sticker system which identified that equipment was clean and ready for use.
- We checked portable appliance testing records for 28 items of equipment and found it in date, meaning that it was safe for use.
- Emergency equipment trolleys and bags contained the appropriate equipment required to manage specific maternity or neonatal emergencies.
- There was adequate equipment available for use including, CTGs, blood gas analysers and resuscitation equipment.
- Two obstetric theatres were co-located on the delivery suite. Elective lists were staffed by a dedicated team to ensure that emergency theatre activity could run alongside, avoiding unnecessary delays to the elective activity.
- The neonatal unit was situated just outside the delivery suite doors. Staff we spoke with informed us paediatric staff could attend emergencies quickly.
- Medical equipment packs such a caesarean section instruments were tracked in and out of the inpatient services using an electronic system to ensure adequate stock numbers.
- The unit had a dedicated birth centre which was suitable for women who were assessed as low risk. The birth centre reflected a 'home from home' environment aimed to help women and families feel as relaxed and comfortable as possible during the birth experience. The

unit had permanent birth pools which were, cleaned, tested and maintained regularly. The staff practiced pool evacuations following a policy to ensure they could assist a mother to exit the pool if an emergency arose.
- The birth centre had mood lighting to enhance a relaxed, calm environment.

Medicines

- Medicines and medical gases were stored appropriately.
- Records showed staff checked controlled drugs in line with hospital policy. Records showed the administration of controlled drugs were subject to a second, independent check. After administration, staff confirmed the stock balance of an individual preparation was correct and recorded the balance.
- A clinical pharmacist visited the wards five days a week. They were involved in discussions with doctors and nurses about patient's individual medicine requirements and helped identify medicine issues which could be dealt with immediately. The Medicine Management Technician advised patients about their medicines to ensure the medicines prescribed were safe and correct. A nurse told us that there was a very good relationship with the clinical pharmacy team with access to a pharmacist out of hours if needed
- Midwife exemptions (medicines midwives are allowed to administer) were appropriate and in date.
- Medicines that required storage at a low temperature were kept in a specific medicines fridge. Staff checked and recorded all fridge temperatures daily. There were no gaps in recording. Midwives and nurses told us they received support from the on-site pharmacist, when necessary.
- The service had an effective self-medication policy which included forms that were signed and dated by patients who consented to self-medicate. We were shown patients' bedside lockers to store medicines. The key was held by the patient. This allowed patient choice and independence in looking after their medicines.
- Medication allergies were appropriately indicated on prescription charts.
- Medicine incidents were communicated to staff in ward meetings and through newsletters.
- Learning from medicine incidents was shared. In particular shared learning of the incorrect prescribing of a medicine for reducing the risk of venous thromboembolism.
- There had been a number of reported incidents for the incorrect prescribing of a medicine by junior doctors to reduce the risk of venous thromboembolism. We were told by clinical pharmacists and midwives that they were aware of this problem and therefore checked for any inaccuracies on prescription charts. A newsletter 'Headlines of the Week' dated 19 to 24 April 2016 reminded all inpatient clinical ward staff to 'check the prescription chart carefully before administering medication'. In response to this increase of reported incidents a strategy was put into place. All junior doctors were to receive training on prescribing the high risk medicine for treating venous thromboembolism at their induction. Also a new prescription chart for venous thromboembolism assessment and prescribing was being introduced. This was to ensure all required clinical information was documented to prescribe the correct dose of the medicine.

Records

- The service kept medical records securely in line with the data protection policy. Records were easily obtained out of hours when women arrived in labour.
- Some documentation such as the recording of cardiotocographs which is the recording of the fetal heartbeat and the uterine contractions during pregnancy, was electronic and could be printed and added to paper notes if required.
- The service was in the process of converting inpatient notes on the antenatal and postnatal wards to a paperless system.
- Staff kept clinical records to a high standard. We reviewed 22 records and saw all contained a clear pathway of care that described what women should expect at each stage of their labour and records were dated, timed, with a signature and identifiable name.
- Women carried their own records throughout their pregnancy and postnatal period of care. The unit used the 'Personal Child Health Record' (known as the 'red book'). This was given to women before the new-born examination and all of the books we looked at were completed correctly.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated, midwife responsible for safeguarding children.

- Staff demonstrated a good understanding of the need to safeguard vulnerable people and understood their responsibilities in identifying and reporting any concerns. All staff we spoke with said they were happy to speak to the safeguarding lead if they had any concerns.
- We saw examples in patient records of processes such as safeguarding and also witnessed how this was applied in practice. For example, a woman undergoing induction of labour had been identified as having learning needs. A detailed care plan was filed in the woman's notes and, in addition we witnessed a consultant obstetrician discussing details of the safeguarding concerns with colleagues.
- Risk assessments and clear care pathways were in line with the trust's 'safeguarding unborn babies' policy.
- Records for the inpatient maternity services showed 100% of staff had completed level one safeguarding training, 83% had completed level two safeguarding children training, and 85% of staff had completed child protection level three training. Safeguarding adults level three training was 90% compliant. The trusts target was 85% compliant.
- The safeguarding team made direct contact with staff who were not able to attend safeguarding training. The team planned and facilitated training around doctors' rotas. If a member of staff cancelled training on more than one occasion, a failsafe system flagged up the missed training and the individual was contacted.
- Leaflets about safeguarding were sent out to staff with their payslips when they were due their training. This process was mainly used for new starters and level one safeguarding training.
- Safeguarding training used different based scenarios from different areas of work, for example; social workers referrals to midwives and onward to health visitors. This meant staff could all see how other areas worked when referring to safeguarding. The training was also interactive, involving participation such as votes on actions delegates would take.
- Staff could easily identify patients with safeguarding concerns due to a purple sticker on patient notes and purple note section.
- There were effective safeguarding referrals in medical notes, with evidence of information sharing with community and inpatient staff.
- The service had a child abduction policy and had conducted a drill of the abduction policy within the last year. The service also had a tagging policy in place. All infants had a security tag fitted which would alarm if they were removed from the ward. If a child was perceived to be at risk, such as all those on child protection plans, the child would be 'double' tagged and the mother and baby would be placed at the furthest location away from the exit on the postnatal ward or close to the nurses' station.
- The service used a closed circuit television system to monitor all individuals attending and leaving the inpatient wards.
- The World Health Organisation defines FGM as "procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons." Senior clinical staff told us there had been training about FGM the previous year, which raised awareness. The trust had a guideline to support staff in the identification of those at risk of FGM and in their management. We observed posters in the staff areas that showed a pathway for reporting concerns. Staff described and understood the pathway to follow if they suspected or identified a patient with or a risk of FGM.
- Information was displayed for staff regarding child sexual exploitation and FGM was included into safeguarding training.
- If staff encountered problems when completing safeguarding referral forms they could contact the safeguarding team for support. The safeguarding team would not fill out the form for staff but used the contact as a learning opportunity to assist the member of staff.

Mandatory training

- Mandatory training was arranged in a block to enable staff to complete it all in one week, facilitating easier compliance. Specific maternity mandatory training subjects included maternal and neonatal resuscitation, electronic fetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping. Compliance at the time of our inspection was 81.7% compared to the trust's target of 85%.
- Multidisciplinary 'core skills' training was in place for all maternity staff to maintain their skills in obstetric emergencies. These included the management of

post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse (when part of the umbilical cord protrudes from the vagina before birth).
- Mandatory training incorporated Practical Obstetric Multi-Professional Training (PROMPT) training in a simulated scenario setting. A competency-based programme for interpretation of cardiotocography was also included in the simulated training. In addition, 'human factors' training had been incorporated into the mandatory programme in an endeavour to improve working relationships between all members of the multidisciplinary team in emergency situations.

Assessing and responding to patient risk

- Robust risk assessments were in place and the unit had developed a number of innovative symptom-specific triage assessment cards. These were in the process of undergoing copyright and were being trialled at other NHS trusts within the West Midlands. This initiative aimed to provide consistency and effective response to risk for patients presenting to obstetric inpatient services across the midlands.
- The service utilised integrated care pathways (ICP) for specific conditions, for example, bereavement care. This process ensured planned care was consistent.
- The unit also had a low threshold for implementation of the high dependency ICP. This ensured any woman whose condition had deteriorated could be identified easily and readily.
- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. Although on reviewing MEWS charts we identified that midwives did not always complete the full set of observations. We looked at six sets of notes and there were gaps in all six thus failing to comply with the purpose of MEWS. We alerted management to the missing observations. Ward champions had recently been introduced to improve education and compliance in specific areas, one of which being MEWS completion. MEWS training was also added to the multi-professional scenario training (PROMPT) from March 2016.
- We witnessed a rigorous multi-disciplinary response to a medical emergency on the postnatal ward.
- The midwifery and medical handover on delivery suite was timely, concise and incorporated updates on women who were not being cared for on the suite but nevertheless may give cause for concern to the oncoming team. The consultant was contacted and kept informed when an emergency caesarean section was performed.
- Appropriate risk assessment was conducted on admission and prior to surgery including venous thromboembolism (VTE) assessment. This was included in the elective and emergency caesarean section patient care plans.
- Patients were triaged in an appropriate time frame on arrival to the service according to their needs.
- The service used an adaptation of the World Health Organisation surgical safety checklist in its obstetric theatres to ensure safety checks were in place before, during and after surgery. Audit of compliance and completion of these forms was completed monthly and submitted to the audit lead every three months. For January 2016 – March 2016 the audit demonstrated 100% compliance and 93-97% completion of the forms. One action plan following the audit indicated the delivery suite matron would discuss with midwives the need to fully compete forms and a 'red hat' wearer in theatre would identify the person responsible for completing the checklist. The 'red hat' wearer is responsible for ensuring the WHO safety check list was completed and all members of the theatre team engaged with the safety check.
- Two weeks before our inspection, the service had implemented the national good practice recommendation of a 'fresh eyes' approach. This was a system which required two members of staff to review fetal heart tracings, and indicated a proactive approach in the management of obstetric risks. Compliance with the new approach for the department had not yet been audited however there was a robust plan in place to ensure a timely uptake of the new initiative.
- For women using maternity services the booking visit took place before 12 weeks of pregnancy. This included detailed obstetric, medical, mental health and social risk assessments. An initial maternity booking and referral form was completed by community midwives at the booking visit. Between April and December 2015 96% of women were seen by a midwife by 12 weeks and six days gestation of pregnancy.

Maternity (inpatient services)

Nursing staffing

- The service met the national benchmark for midwifery staffing as set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of one midwife per 28 patients.
- The unit held twice-daily staffing huddles supported by a robust safe staffing and escalation protocol should staffing levels by shift fall below the agreed number. The escalation plan ensured one to one care in labour remained a key priority. We observed that one to one care was maintained and we saw information form the trust to support this. The escalation policy was used in incidences of non-planned staff shortages such as sickness. During our inspection period there was one incident of the escalation policy being used due to five out of 12 midwives being off sick for a shift due to an acute virus.
- The directorate management team told us they were aware of the effects staff movement can have on postnatal care, but staff told us the initiation of the escalation plan meant that whilst patient care was protected, staff meal breaks were missed.
- Staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing numbers.
- Staffing numbers were integrated into the services risk dashboard. This provided an immediate identification if staffing levels posed a risk to safe care.
- If staffing on the inpatient wards fell below a safe standard, a red flag was raised on the quality matrix as well as an incident report. The reason for the staffing shortage was then investigated.
- The service used a midwifery workforce planning tool which was recommended by the Department of Health, endorsed by the Royal College of Midwives and incorporated in standards issued by the NHS Litigation Authority. This tool enabled the impact of planned workforce change to be clearly mapped, to support service improvement and planning for personalised maternity services.
- Recruitment had previously been on hold due to a trust wide policy. However, at the time of our visit there was a recruitment plan in place and an agreement from the executive board to over recruit. This meant there would not be shortfalls when existing staff left the organisation.
- The funded establishment for midwives was 283.4 whole time equivalent (WTE); however, the directorate was permitted to recruit to 290 WTE to mitigate for retirement and resignation.
- At the time of our inspection there were 15.4 WTE midwife vacancies, and the trust had recruited 12.4 WTE midwives. From April 2016 the trust had implemented a new resignation process. Staff up to band four were required to give four weeks' notice, band five staff eight weeks' notice and staff in band six or higher 12 weeks' notice. This improved the recruitment process and management of turnover, and mirrored other trusts within the area.
- Due to staff shortages, maternity leave and sickness at the time of our inspection there was a 9.5% bank and agency midwife usage. Agency use was minimal: 14 shifts in total for the six months prior to our inspection. All bank staff used at the unit were familiar with the service and received an induction programme.
- The service's average sickness rate was 6.5% for the six months prior to our inspection, which was above the trust's target of 4%.
- Senior managers told us they had been through a difficult period with low staffing due to sickness, maternity leave, vacancies and a high volume of activity in February and March 2016. Information on patient incidents presented to the performance board had demonstrated that despite the difficulties encountered, the service remained safe during this period. There were no serious incidents from January to March 2016. The trust expected this short term problem to be resolved with an influx of new staff in May 2016. To provide additional reassurance, an analysis was planned for quarter two, 2016/17, using the workforce planning tool. This would ensure managers could robustly calculate staffing levels.
- We spoke to three student midwives who all said they were always supernumerary to staffing levels.
- The serviced utilised the NICE 'red flag' system that alerted when patient safety was compromised due to staffing issues for example, delay in suturing or not achieving one to one care in labour.

Maternity (inpatient services)

- The serviced used a text messaging facility to alert staff to available bank shifts. Staff also used a closed social network page to discuss and arrange exchanges of shifts or bank shifts.

.Medical staffing

- There were 57 whole time equivalent medical staff from junior doctors to consultant posts. The proportion of junior and senior doctors and consultants was the same as the national average. The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours work when they were on call for the obstetric unit.
- The inpatient service had two specialist registrars and two senior house officers available during week days and two registrars, one senior house officer for delivery suite and one for the wards at weekends. This was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- Consultant hours on site from January 2014 to June 2015 ranged from 90-120 hours coverage per week which was below the RCOG recommendations of 168 hours for the number of births. Recruitment plans were in place to increase consultant posts although the RCOG recognised in its recommendations that the larger the unit, the greater the difficulty in achieving the recommendations purely on financial terms. The trust said it was unable to increase its consultant cover further on the delivery suite to 168 per week due to the significant financial implications.
- Two consultants were present during the day time; one for elective admissions and one for inpatient activity on the delivery suite.
- A consultant was resident on delivery suite for three nights out of seven; there was a consultant off site on call at all other times. They were able to attend the unit within 30 minutes if required.
- Anaesthetic doctor cover was sufficient with two consultants and two trainee doctors available during the weekdays, one resident doctor available on site 24 hours a day and a consultant on call from home during evenings and weekends.
- Advanced nurse practitioners mitigated risks of medical staffing levels by supporting the medical team with areas of clinical expertise.

Major incident awareness and training

- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- A staff information sheet was available which explained to staff what a major incident was and how they would be required to respond if such an event occurred. Each ward had an up to date log of all staff telephone numbers and addresses.
- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

Are Maternity (inpatient services) effective?

(for example, treatment is effective)

Good

We rated effective as 'good' because:

- We saw evidence-based care and treatment was provided and audited appropriately.
- A wide range of pain relief options was available to women supported by information to help them make an informed choice.
- Patient outcomes were monitored effectively using a maternity dashboard system.
- The target for breastfeeding initiation rates was being met and there was a detailed action plan to address the neonatal readmission outlier.
- Staff were provided with support and education to be competent in their practice.
- We observed excellent multidisciplinary team work.
- Staff had a good understanding of the Mental Capacity Act 2005.

However we also saw;

- Neonatal readmissions due to related feeding issues was raised as a concern because it was above the national accepted target.

Evidence-based care and treatment

- Staff were consulted and involved with the development of guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice.
- Policies were all in date and in line with best practice.
- The care of women using the services was in line with the Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, education and training and professional development.
- Care was provided in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy.
- Caesarean section procedures were managed in line with NICE Quality Standard 32. This included detailed discussion with a consultant around choice of birth mode and debrief after the caesarean with advice given for future pregnancies.
- There was evidence to support that NICE Quality Standard 37 guidance was being met. This outlines the expected standard a woman and her family may expect to receive during the postnatal period. For example, we observed that women were advised within 24hours of the birth, of the symptoms and signs of conditions that may increase the risk of harm and require them to access emergency treatment.
- A pathway was in place for women who experience significant perineal trauma during birth (third or fourth degree tear). The pathway provided consistent information for women and supported a timely transfer home. This pathway was developed in line with the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No. 29: The management of third and fourth degree perineal tears (2015) compliance with the pathway and therefore the national standard was last audited from June to January 2016. The audit demonstrated good compliance with 18 out of the 23 outcomes audited being compliant, an action plan detailed areas for improvement and continued good performance prior to the next audit to improve standards. The service had also adopted recommendations that the patient was supported by a named urogynaecologist and specialist midwife.
- The service participated in a significant amount of clinical audit in order to continuously improve patient care and safety. An example of this was the second theatre team response time to emergency sections. The audit found in some historical cases there had been a delay in staff being available on site. As a result, the audit senior management were reviewing solutions and considering an onsite second theatre team.
- The haematology specialist midwife audited care of patients with haemoglopinopathy, an inherited blood disorder, including, treatment, medication types and dose. The results were 98% of patients were receiving correct treatment. An education programme was set up for one to one training in conjunction with the pharmacy department to address the 2% of patients who had not received correct doses of medication. A laminated table of doses required for anti-coagulants was placed in obstetric theatres and an email was sent to every supervisor of midwives to facilitate discussion to increase the midwives awareness.
- The critical care policy and guidelines were formed by a collaborative workforce of Birmingham Women's Hospital and University Hospital, Birmingham and followed the recommendations of the Association of Anaesthetists and the national critical care guidelines.
- Patients with risk factors for gestational diabetes were identified and offered glucose tolerance testing as highlighted by MBRRACE-UK (2015) , which is programme of work comprises national surveillance of late fetal losses, stillbirths and infant deaths, and in line with the current NICE guidelines.
- Patients with multiple pregnancies were managed in accordance with NICE guidelines.

Pain relief

- A wide range of pain relief was available including and ranging from 24 hour epidural service, remifentanil analgesic drug infusions to water immersion and aromatherapy.
- Detailed information regarding pain relief options available was provided to patients in the antenatal period.
- Documentation we reviewed demonstrated a continuous assessment of patients' pain relief options whilst in labour.
- Women who requested epidural anaesthesia received it within 30 minutes.
- Twenty Four percent of women giving birth at the services received an epidural during labour. Patients who received an epidural during labour were followed

up the next day to check if the epidural was effective. In 2015, 78% of patients were satisfied with their epidural during labour, 9% of women were not followed up due to being discharged before review and 13% had either a partial, late or no analgesia relief from the epidural.

Nutrition and hydration

- The trust had implemented the United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards for breastfeeding. They had achieved and maintained the highest level, 'level three baby friendly accreditation' since 2013.
- The service's breastfeeding initiation rates were 75.7%, above the trust's target of 75%, during 2015/16.
- The service had a specialist midwife with a strategic lead for infant nutrition; this role included training staff and breastfeeding peer support for volunteers.
- The trust acknowledged poor breastfeeding support had resulted in an increase of neonatal readmissions due to related feeding issues. This had been raised because it was above the national accepted target. The service had developed an action plan to address these issues. The action plan was comprehensive and we saw target completion dates were on track to be achieved. Nine extra support staff had recently been recruited and trained to offer breastfeeding support in an attempt to improve skin to skin contact for new-born babies and improve breastfeeding initiation rates.
- Women who accessed the birth centre used 'smoothie' making equipment to help meet their nutrition and hydration needs in labour.
- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements.
- The hospital's 2016 'Patient Led Assessment of the Care Environment audit' identified a score of 96.8% for ward food.

Patient outcomes

- Birmingham Women's Hospital used the RCOG Good Practice No. 7 'Maternity Dashboard: Clinical Performance and Governance Score Card. The maternity dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- The service collected monthly data on outcomes of women's care and treatment and incorporated it into a monthly performance and quality report. They benchmarked their performance against other maternity services within the West Midlands. The hospital's performance statistics in the percentage of women achieving a normal vaginal birth were below the national target but were comparable to other tertiary level maternity services. This was because of the higher risk and complexity of women referred for this specialist service.
- One to one care during labour was audited and reported on the risk dashboard. Since August 2015 all women in active labour at the hospital had received one to one care.
- Women presenting in triage were seen in a timely fashion. Ninety-nine per cent were seen within 30 minutes of their arrival, against the trust's 95% target.
- The trust began collecting data on delays in perineal suturing, commencement of induction of labour or category one caesarean sections in July 2015. Since that date no delays had occurred.
- For the period of July 2014 to June 2015 emergency caesarean section rates were 16%, which was comparable to the England average of 15%. For elective sections, the service achieved 11% which was the same as the England average.
- The service achieved a normal vaginal delivery rate of 57%, which was slightly worse than the national average of 60% but was comparable to other, similar specialist units.

Competent staff

- New starters were given an induction period incorporating mandatory training. This was initially for a month but adjusted to suit individual staff needs. A preceptorship package was available for newly registered midwives. Two preceptorship midwives told us they felt the programme prepared and supported their development for a band six midwife post.
- Midwives who cared for women in the high dependency rooms had to complete a high dependency competency booklet to ensure they were competent in their care.

- The birth unit had an aromatherapy lead midwife who had untaken appropriate training. They had written the policy for use of aromatherapy on the birth unit and delivered training to other midwives on the speciality.
- Several midwives had undertaken the New-born and Infant Physical Examination course so they could discharge low risk babies following birth. The framework within which they practised was clear and included a detailed list of neonates (babies up to 28 days old) they could review and those who needed referring to a neonatologist.
- At the time of our inspection, in February 2016, 81.3% of midwives had received appraisals compared to the trusts target of 85%; outstanding appraisals had been allocated appointments for completion.
- Revalidation was part of the appraisal process for medical staff and was co-ordinated by the medical director's office. Staff we spoke with reported no difficulty in arranging to have an appraisal completed.
- All midwives had a named supervisor of midwives (SOM). Staff said they had access to and support from a midwifery supervisor. They reported the process was very similar to the annual performance review. The ratio of SOMs to midwives was one to 15 which was slightly above recommendations from the Nursing and Midwifery Council.
- The wards had a champion scheme where members of staff with an interest in a specific area, for example wound care, would receive additional training. They acted as a referral point, educator and source of knowledge for the rest of the staff.
- Daily teaching sessions took place on the delivery suite, during which cases and management of patient care from the previous 24 hours were discussed and constructively challenged.
- The results of the General Medical Council National Training Scheme Survey 2015 showed educational and clinical supervision, induction and experience for junior doctors was within expectations for this trust.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were supported by the ward team and could approach their seniors if they had concerns.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.

Multidisciplinary working

- We observed excellent multidisciplinary working on the wards, in theatres and on the delivery suite.
- All staff, including those in different teams and services, for example, consultants, nurses and midwives worked collaboratively and respected each other's roles to ensure they provided the best possible care to their patients.
- In theatres, the team brief and use of the World Health Organisation's 'Safer Surgery Checklist'. The process was rigorous to ensure patients' safety and was respectful of individual team members' priorities. We observed healthy challenging of decision making involving questioning of a judgement made by a midwife.
- We saw collaborative working both within the team and incorporating a wider specialist team off site for women with complex conditions. One example of this involved a patient who was receiving palliative care at another trust.
- Multidisciplinary team working was apparent between obstetric and neonatal service for the management of patients with multiple pregnancies.
- The critical care lead was instrumental in the implementation of pathway development for women who gave birth at other trusts but were cared for with the speciality knowledge of this trust's clinicians.
- There was access to 24 hours a day, seven days a week support from a neonatal specialist medical staff.
- The lead midwife for haemoglobinopathys which is a hereditary condition involving an abnormality in the structure of haemoglobin, provided excellent care for women by co-ordinating a team of consultant haematologists for another trust, laboratory support and inpatient services.
- A range of staff from different disciplines assessed, planned and delivered women's care and treatment. The service participated in regional and local multidisciplinary teams such as the collaborative birth centre admission criteria which aimed to provide consistency across the region.
- Women had access to interventional radiology for cases of placenta praevia (where the placenta presents before the fetus). This service was available in main theatres before elective caesarean section and performed in partnership with the radiology team. Women with placenta accretia where all or part of the placenta attaches abnormally to the uterus, gave birth at another local trust where intensive care facilities were

immediately available because of the risk associated with the condition. In this situation, midwives and doctors from Birmingham Women's Hospital provided support to the intensive care team at the other hospital.
- We observed communications with GPs summarising antenatal, intrapartum (during pregnancy) and postnatal care in medical records.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacists. Midwives at the hospital worked closely with GPs and social services while dealing with safeguarding concerns or child protection risks.
- There was an integrated pathway for potential victims of domestic violence, which included robust, proactive processes to give potential victims numerous opportunities to tell staff about any issues they had experienced.
- The safeguarding team contacted the multi-agency safeguarding hubs if they required support with difficult cases and they had an effective relationship with social workers in the region.
- The service ran a 'safeguarding week', during which outside speakers from multi-agency safeguarding hubs and the police provided training to raise awareness of safeguarding.

Seven-day services

- A full team of staff including doctors, midwives, midwifery support workers and administration staff were available 24 hours a day, seven days a week for the inpatient services.
- An obstetric theatre team was staffed and always available. A second team was also on call out of hours if two emergencies arose at the same time.
- An anaesthetist was available 24 hours a day, seven days a week and a second anaesthetist was available should the need arise. An appropriately trained anaesthetic assistant, also present on the labour ward 24 hours a day, supported the anaesthetist.
- Patients had seven day service access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography and pathology.

Access to information

- Medical and clinical staff told us they had access to guidance, policies and procedures on the hospital intranet.
- Routine and emergency bleep numbers were displayed in several locations within the inpatient service to assist staff when contacting other professionals.
- Staff information boards included incident and complaints learning, maternity dashboard information and key safety messages.
- Copies of the delivery summary were sent to their GP and health visitor to inform them of the outcome of the birth episode as soon as the birth occurred.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms for women who had undergone caesarean sections and instrumental births detailed the risks and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- Clinical staff were clear about consent processes for procedures for both verbal and written consent. Staff understood the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Consent for episiotomy and perineal suturing was detailed in the birth notes with evidence of discussion of treatment options by the midwife.
- Staff carried a MCA prompt card which reminded them of the key points in assessing mental capacity.
- Training on the MCA and DoLS was included in safeguarding training.

Are Maternity (inpatient services) caring?

Outstanding ☆

We rated caring as 'outstanding' because:

- People were respected and valued as individuals and empowered as partners in their care.
- Feedback from people who use the service, and those who are close to them was continually positive about the way staff treated people.
- Doctors and anaesthetists played with the children of women who received care and promoted a whole family approach to care.

- People told us staff went the extra mile in supporting women and provided continued help and advice to women who wanted to breast-feed.
- Staff were highly motivated and inspired to offer care.
- Staff took people's personal, cultural, social and religious needs into account and actively engaged with people to provide cultural sensitive care and treatment at every given opportunity.
- People's emotional and social needs were highly valued by staff and embedded in their care and treatment.

Compassionate care

- Maternity contributed to the NHS Friends and Family Test (FFT). For the last financial year, 89-100% of patients would recommend this trust to a friend or family out of a total of 439 responses. To enhance feedback rates volunteers circulated around the wards distributing information on FFT.
- We observed caring and compassionate interactions between staff and women, when new mothers felt they needed to talk or they felt anxious staff would speak with them even in the middle of night and looked after their baby overnight so the mother could catch up on their sleep.
- Staff always introduced themselves and wrote the name of the midwife in charge of their care for that shift on a white board next to each bed, midwives who were not allocated for the patient still answered nurses call bells and offered their assistance and went round the ward to ask if they could assist with anything.
- All women we spoke with said they felt listened to. One mother was unable to pick up her baby because an intravenous drip was in the way; she raised this with the staff who assessed the situation and re-sited her drip to the other arm.
- All women described staff as "friendly" she said ward staff who were not appointed to her always asked how she was and introduced themselves and said hello.
- Staff were described by many patients' as "caring", "compassionate" and "professional" one woman said "she couldn't fault the service" and "everyone was open and honest".
- We spoke with a mother who came in for an elective caesarean section, felt reassured as she said she was able to meet her anaesthetist before she had her caesarean. The anaesthetist was able to reassure the mother's concerns and was able to answer all her questions, gave her the time she needed to feel at ease.
- Patients felt they knew the staff personally. Patients' said staff were approachable and patients' felt they could raise concerns any time of the day as staff were highly compassionate and demonstrated a 'nothing was too much trouble' attitude.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. Partners of pregnant women told us that they felt included and well informed.
- We spoke with a couple who had three children born in different hospitals; they said they were very impressed with their care at Birmingham Women's Hospital. They said "this hospital was the best of the three." They felt that although the staff knew they had already had children, staff still gave them the same help and support, as if this was their first.
- We spoke with a mother who had a Muslim belief; she told us she was pleased her family could come in at any time, the grandmother visited outside visiting hours to say a prayer into the ear of the baby. The grandmother was also allowed to go in to examine the baby, and check its ears and nose and the mother felt pleased her families' religious and cultural needs were supported.
- Many women said they could choose whether they wanted their curtains in their bay drawn or not.
- Many liked their curtains open so they could speak with other women and exchange their experiences.
- Patients said they were very impressed with the Patient Advice and Liaison (PALS) team who did regular 'walkabouts' and spoke with patients about their care experience and many patients felt reassured if they had an issue they could raise it. One mother said she has used PALS in the past to send out compliments and had received a personal response from PALS.
- Patients felt listened to, understood and involved regarding choice of pain relief.
- One woman said consultants and junior doctors always checked on how well she had slept and involved her with the 'plan' for the day. Women were given the opportunity to make informed choices about the availability of birth settings that were appropriate and safe for their clinical needs and the risks involved.

- We saw a doctor and anaesthetist fully engage with women and their families and brought toys to siblings to play with them whilst speaking to their parents, this promoted a whole family approach to care.

Emotional support

- One woman said she felt supported as staff arranged a volunteer to talk to her and give advice about breastfeeding. A volunteer demonstrated how to hold the baby, gave her different techniques she could use to help support her baby to breastfeed and the volunteer returned later in the day to see how she was progressing. Volunteers would come in on different days in their own time to visit the women they had advised to see if they required more support and if they were settled.
- One woman felt very anxious when her husband was not there and she felt staff were always there to help. Staff offered breastfeeding support and advised her how to hold her baby. With the mothers permission a staff member settled the baby and offered to contact her husband for the extra support.
- Patients' told us staff offered emotional support, their family were allowed to visit anytime for additional support from loved ones and staff were also very supportive towards their partners.
- Another patient said she was physically helped to attend a prayer room; she was pleased when staff allowed her to have her husband present for longer periods in the evening past the allocated time due to his work commitments.
- Staff made time even when busy to offer emotional support for mothers. One mother said when she felt very anxious at around 3am a nurse came and sat with her and had cup of tea so she could chat about her anxiety.
- Partners were allowed to stay only on occasions where mothers were very anxious and required their partners for the support.
- The bereavement service provided emotional and practical support to all women who suffered pregnancy loss from 16 weeks gestation. Staff were supported in the delivery of care to bereaved parents by the use of an integrated care pathway. In addition to this there were three guidelines pertaining to: Care of the woman and her family, Care of the baby, documentation, certification, Coroner's cases, registration and funeral options.
- For mothers and partners who had suffered a pregnancy loss, the consultant organised a bereavement counsellor. This support was also extended to her partner and children; one woman told us this service was "amazing."
- Staff offered to accompany mothers to scan appointments for support when required.

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

Good

Are Maternity (inpatient services) responsive?

We rated this service as 'good' for responsive. This is because:

- Religious guidance from all denominations was available to support mothers and their families.
- The service consulted with patients to identify what would make their hospital stay more comfortable.
- There were arrangements to support individuals with complex needs, with access to clinical specialists and medical expertise.
- Bookings for pregnancy and birth at the trust were capped to ensure demand did not exceed capacity.
- There was a robust high activity escalation policy. Escalation was co-ordinated by 24 hour site management.
- Complaints and concerns were included on a performance dashboard and regularly monitored; responses to complaints were appropriate and actively engaged the patient in service improvement.

However we also saw;

- The birth centre had closed on a number of occasions because of high demand within the obstetric led service.

Service planning and delivery to meet the needs of local people

- The service consulted with patients throughout the pregnancy journey to identify what would make their hospital stay more comfortable.

- A postnatal debrief service was available for all women following birth to support emotional wellbeing. This encouraged patient engagement and feedback and reduced the number of complaints.
- In response to a patient survey the inpatient wards extended their visiting hours to meet the needs of the patients.

Meeting people's individual needs

- There were arrangements to support individuals with complex needs, with access to clinical specialists and medical expertise. For example, arrangements were put in place to support a woman with complex health and social care needs. There was a network of midwives and consultants with special interests in teenage pregnancy, haemoglobinopathys drug and alcohol, perinatal mental health, bereavement, smoking cessation and high risk pregnancy.
- Post-mortem examination was offered in all cases of stillbirth and neonatal death **i**n order to improve future pregnancy counselling of parents.
- We saw a range of patient information leaflets which were readily available in patient access area.
- In the review of six sets of notes we saw evidence of planning and assessment of care.
- A pictorial explanation poster was displayed in theatre's recovery area to inform birth partners of the process and steps involved with emergency and elective caesarean section. This was in response to feedback received from a patient's partner.
- Midwifery staff described their role in supporting individuals who had learning disabilities. The emphasis was around ensuring the individuals concerned understood the provision of maternity care. Next of kin and carers could be involved and, where necessary, social services to ensure the best outcomes for parents and their child.
- The trust used specific notes for patients with learning disabilities. These notes had larger print and were illustrated to help patients understand.
- A video recording booklet was available in each department for those who were hearing impaired or unable to read.
- Referral forms for specialised health services for those with additional needs were available such a physiotherapy.
- We observed a detailed advocacy information folder for families and patients.
- There was a translation service available for women whose first language was not English. Staff explained how the translation service was accessed and used and this worked well in practice.
- The delivery suite and some postnatal side-rooms had en-suites and partners could stay on a reclining chair when necessary.
- The service had made appropriate adjustments to ensure women with a disability had access to suitable facilities. This included adapted bathroom and toilet areas. Specialist equipment for women with a high body mass index (BMI) was available when required.
- The trust had recently introduced a 'no pass zone' programme which had informed staff that any
- staff member can answer a patient buzzer not just the person in charge of the patients care. This aimed to reduce response time to patient's needs.
- All birth rooms had docking stations which enabled women to bring in their own choice of music to be played during labour. Patients had access to an outside garden space if they wished to mobilise in labour.
- The services had two dedicated rooms for women and families who had experienced loss of a baby. The rooms were comfortably furnished with a homely feel such as tea and coffee making facilities and televisions, and had facilities for partners to stay overnight. Each room had access to an adjacent room where families could spend time with the deceased if they wish to do so.
- The chaplaincy services were multi denominational and provide a facility adjacent to the mortuary for the 'shrouding' of babies who had died that were born to Muslim parents. In addition, a keepsake box for parents which was mindful and respectful of Islam (phials of the perfume used to prepare babies rather than the angel included in other boxes).
- Religious guidance from all denominations was available including Rabbi and Hindu pujari.
- Adjacent to the chapel was a prayer room used by all religious denominations and a wudu (ablutions room for Muslim users).
- There were no visitors toilets located on the postnatal ward floors and visitors and partners had to travel to the floor below to use facilities.
- Patients who used the women's health services had access to informative literature. We saw examples on display, such as what to expect during a caesarean section, positions for active birth and promotion of breastfeeding.

- Women had access to the Birmingham Women's smart device application which provided them with information about the service.
- Pregnant women and their families could access this site and take a virtual tour.

Access and flow

- Bookings for pregnancy and birth at the trust were limited to ensure demand did not exceed capacity.
- Bed occupancy for 2014/15 was between 64% and 72%, however for 2015/16 the bed occupancy ranged between 72% and 82%. Both years were higher than the national average for bed occupancy whichranged between 57% and 60%, whilst for 2015/16 across the quarters it was 60% to 62%
- There was a robust high activity escalation policy. Escalation was co-ordinated by a 24 hour site management team. Some midwives reported feeling disgruntled that they were asked to move areas as a result of initiation of the escalation policy, whilst others acknowledged this ensured the service was both responsive and safe. The escalation policy involved the need for decision making from a site manager. If the manager was not experienced in maternity provision a maternity manager was on call for advice.
- The criteria for birth within the birth centre had been extended to incorporate women undergoing induction of labour to ease demand on the obstetric labour ward whilst still maintaining safety for the woman and her fetus.
- The postnatal wards had a new-born and infant physical examination clinic situated between the wards. This clinic was run by a midwife with appropriate qualifications, a neonatal doctor and a maternity assistant. Patients took their baby to the clinic at an allocated time as this facilitated a smooth flow during the discharge process. If a patient was unable to mobilise to the clinic the team would facilitate a bed side examination of the baby to ensure the mother and family were involved.
- The birth centre had closed on a number of occasions because of high demand within the obstetric led service. This data was collected monthly and fed back to senior management to assist with planning service needs.
- The directorate team acknowledged delays were experienced by women waiting for transfers to the delivery suite for artificial rupture of the amniotic sac (amniotomy). The service mitigates the potential risk of the delays by the use of an induction of labour database. At periods of high demand the consultant obstetrician on duty on the delivery suite reviewed the risk factors of the women waiting within the unit and also those at home. An audit of the number of women and the amount of time delayed had commenced prior to our inspection. It was too early for data to be analysed but this was an ongoing process to reconfigure service provision.
- Senior staff we spoke with and evidence provided by the service showed the service had not closed to admissions or deliveries for several years before the inspection.

Learning from complaints and concerns

- Complaints and concerns were included on a performance dashboard and regularly monitored.
- Ward sisters and matrons participated in daily patient feedback rounds where all patients were asked if they were satisfied with their care. Complaints and concerns could then be immediately acted upon.
- Both formal and informal complaints were treated with the same seriousness by the service. Staff offered to meet the complainant when complaints were received; this was supported by the PALS team. Meetings were followed up in writing, detailing the outcome. Between January 2015 and June 2015, the service received 21 formal complaints. We reviewed a sample of complaints and the outcomes of the complaints were appropriate; duty of candour was applied where required. Themes of these complaints included communication and staff attitude.
- Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days. Complaints were kept under review at the maternity governance meetings
- PAL's leaflets were available in the clinical areas and these included details of the Healthcare Ombudsman.
- The bereavement service provided an example of learning from a complaint which involved portering staff and we were assured the learning had been embedded within the service as a result of relevant training.
- Patients raising concerns or complaints were actively engaged with improving the service. We observed a patient who had previously raised a complaint and was subsequently involved in the maternity service liaison committee to improve care standards.

Maternity (inpatient services)

Are Maternity (inpatient services) well-led?

Outstanding ☆

- We rated this service 'outstanding' for well-led because:
- The maternity service had a clear vision for the future.
- Driving patient experience and safety though a holistic family approach was at the heart of the service.
- All staff were very clear of the governance and management structure within the service.
- Risk management was understood from ward to board and fully embedded with the service.
- There was a clear managerial structure, which included strong clinical engagement.
- All staff reported excellent local leadership within the directorate and described leaders as visible, approachable and supportive.
- Staff were actively encouraged to follow a specialist interest within the service and they were supported throughout to achieve their professional goals.
- A serious incident occurred; we observed that the patient's family stood at the heart of the incident supported by staff and managers. Senior staff exhibited behaviour above and beyond expectation to ensure staff were supported in every way possible.
- The public voice was actively sought with service development and improvement.
- Innovation was supported and encouraged within the service.

Vision and strategy for this service

- The service was undergoing a significant period of change due to an acquisition by another local specialist hospital.
- The maternity service had a clear vision for the future. A draft 'model of care' overview paper and the supporting strategy document underpinning the vision showed good evidence of this. The Head of Midwifery (HoM) told us they had mapped pathways and identified areas to improve patient care. The first three years had focused on operational issues particularly around staffing, training, and support roles. Objectives set were achievable and included innovative ways of working to improve experience.
- Driving patient experience and safety through a holistic family approach was at the heart of the service.
- The National Maternity Review published its final report on 23 February 2016 and set out recommendations for the future shape of modern, high quality and sustainable maternity services across the NHS in England. The trust had applied for funding to become one of the Maternity Choice and Personalization Pioneers, and were in the first stage of implementing the recommendations from the National Maternity Review.
- Partnerships with other trusts, clinical commissioning groups and other stakeholders was evident and part of the present strategy and ongoing vision for the service.

Governance, risk management and quality measurement

- All staff were very clear of the governance and management structure within the service. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. Staff were able to articulate their individual accountability within the governance framework and how poor care was escalated.
- Individual departmental risk registers were in place and reviewed monthly; they reflected the risks clinical staff were concerned about. For example, the midwife staffing numbers.
- Risk management was embedded with the service. Band six midwives led on incident investigations in their area when appropriate, the results of the investigation were fed up to a multidisciplinary risk group. The risk group evaluated each other's investigations and offered healthy challenge and analysed themes. The risk group then fed up to the corporate governance group.
- Performance and outcome data was reported and monitored through the performance matrix. Any outliers (services lying outside the expected range of performance) were reviewed and timely action taken.
- The major risk for all areas was staffing. We were told there had been a rolling programme of recruitment which was discontinued in November 2015. The effect of the cancellation of the recruitment programme was instantaneous and was reintroduced six weeks later however the ripple effect on staffing levels was still

being felt up to 18 weeks later. Staffing was evaluated on a monthly basis in conjunction with six monthly skill mix reviews. A plan had been agreed to over recruit to cover staff absences such as maternity leave and sickness. Staff contracts had also changed to increase the notice period to enable the recruitment process to progress effectively before the member of staff left.

- The senior management had completed a gap analysis following the publication of the Kirkup report (2015). All identified gaps had clear actions documented against them which had been completed.
- There was cohesion between the supervision structure and the investigation into incidents and complaints. Supervision had a clear role and was actively engaged within investigations and staff development.

Leadership of service

- There was a clear managerial structure, which included strong clinical engagement.
- Leadership was encouraged at all levels within the service. The Head of Midwifery (HoM) had access to the executive board and team leads were supported to complete a relevant leadership course.
- Ward sisters participated in one to two clinical shifts per month to enhance patient and staff engagement.
- The Head of Midwifery and matrons where actively involved within the daily activity of the unit and provided excellent support. Senior management attended bed meetings and worked clinically to support staff during challenging shifts.
- Senior management had an in-depth knowledge of the members of the maternity staff team; they knew staff by name and we observed knowledge of their work interests and an informal chat about personal life. Staff told us this contributed to excellent team work.
- The HoM and clinical director had a clear vision for the development of the service. They had an excellent grasp of the challenges within the service and innovative solutions to develop maternity services. Senior management worked cohesively with the medical body to develop the service.
- Staff were clear about who their manager was and who members of the senior team were.
- The board team were visible and facilitated monthly meetings for all employees to attend. The meetings were recorded and available for those who could not attend.
- Women told us they felt fully supported to make informed decisions regarding their care. We saw an example of partnership working in a woman receiving palliative care which was sensitive not only to the wishes of the woman but also her family. All staff reported local leadership within the directorate was visible, approachable and supportive.
- The supportive nature of the local management team was endorsed by staff who reported that all members of the local management team had an open door policy.
- Staff reported the levels of management above directorate level were less visible although it was acknowledged by some staff that the proposed acquisition of the service by Birmingham Children's Hospital NHS Foundation Trust was a positive development.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred and use them to learn and improve practice.
- The service provided several examples where duty of candour had been applied appropriately; staff discussed practising with an open and honest culture. Training and support was available for all staff in relation to duty of candour.
- Although the trust did not employ a full time supervisor of midwives, supervisors told us they felt supported within the organisation and midwives reported being engaged and supported by the supervisory system.
- There was strong team working with medical staff and midwives working cooperatively and with respect for each other's roles. Staff respectfully challenged each-others clinical decisions in the theatre environment to ensure patient safety was maintained.

Public engagement

- The Maternity Services Liaison Committee was well attended with representation of service users and staff.
- A consultant midwife actively engaged with a local National Childbirth Trust Group when developing pathways to encourage active birth. An example of this was the development and provision of a bespoke service for those women contemplating a vaginal birth after caesarean section.

- The trust website actively encouraged patient feedback through a variety of different ways including: a video link so patients could record and send in their comments, mobile phone apps, a patient survey, a telephone contact number and an email address.
- The trust had a new parent and patient advisory council; patients could either attend the meetings in person or 'virtually' by joining their mailing list. The council met approximately six times a year. Council members were consulted on service improvements, key staff interviews and literature for patients and parents.
- The trust website had used information such as a pictorial leaflet for positions in labour.

Staff engagement

- Staff reported they felt empowered. They felt able to voice and escalate concerns.
- We repeatedly heard staff at all levels stating they felt engaged and involved in service development.
- A staff stress assessment had been recently introduced to identify what support a staff member required if they were suffering from stress.
- Staff felt they were valued and their ideas were listened to and embraced when developing the service. This was particularly relevant with complaints and incidents. For example, the development of the sepsis 'grab box'. An incident had highlighted a delay in the administration of an intravenous antibiotic to a patient presenting with sepsis. Staff were involved with the investigation of the incident and the issues that caused the delay. This resulted in a treatment box where all blood sample bottles, equipment for administration of antibiotics and antibiotics were stored in an easily accessible place.
- The HoM had strong links with a neighbouring trust and staff felt involved with improving maternity services across the Midlands area.
- Staff felt proud of the organisations and felt it was leading the way in maternity care provision.
- There were no directorate specific results in the 2015 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.80. This score was the same as other acute trusts but slightly less than other specialist trusts (3.94)
- All staff spoke positively and were proud of the quality of care they delivered.
- Staff repeatedly told us about the 'fantastic team work' within the service that kept people going even when the unit was busy.
- Staff were actively encouraged to follow a specialist interest within the service; they were supported with training and work commitments. Staff were then encouraged to use their knowledge to train others; an example of this was a midwife on the birth unit who had completed an aromatherapy course and subsequently trained other midwives.
- A serious incident had recently occurred and senior staff exhibited behaviour above and beyond expectation to ensure staff were supported in every way possible. All members of staff who had been involved with the care of this patient were individually contacted to be informed of the incident. On the same day a councillor and religious support group was available in the department for staff to speak to. Senior staff were continuously visible and offering support in the days following the incident. Staff directly involved had a staggered return to work when able to do so; this was facilitated by staff changing shifts and senior staff providing clinical shifts. During our unannounced visit staff told us they had been kept up to date with the investigation of the incident and their account of events and personal feelings had been actively sought out and listened to.

Innovation, improvement and sustainability

- The bereavement service had developed an integrated care pathway for bereaved parents to ensure consistency regarding information provided and had been developed to reflect the needs of the service users.
- The trust had implemented the United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards for breastfeeding. They had achieved and maintained the highest level, 'level three baby friendly accreditation' since 2013.
- The symptom specific triage assessment card delivered consistency and clear targets for the triage process. The development of the tool also demonstrated excellent multi-disciplinary working. It was apparent the mutual respect of individual roles and responsibilities was deeply embedded within the organisation.
- The critical care education programme offered other organisations the opportunity to attend education

sessions to gain competency in this specialised area. Other trusts could also access advice and support from the critical care lead. This aimed to improve the critical care of patients across the region.

- BWHFT was amongst 20 hospitals shortlisted for the NICE service innovation awards; they had presented a poster and spoken at the NICE National Conference 2015.

Maternity (community services)

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The community midwifery service at Birmingham Women's NHS Trust is part of the Maternity Directorate and provides assessment, care and advice to women during pregnancy and after the birth of their babies.

A dedicated home birth team provides care to women who wish to give birth at home. This service is an ongoing pilot project and is partly funded by the local Clinical Commissioning Group (CCG). There were 98 homebirth as part of this service in 2015.

58 midwives and eight maternity support workers operate from four bases in the South Birmingham area:

- Charlotte Road area
- Quinton Lane area
- Stratford Road area
- Weoley Castle area

Each team has an administrative officer who made appointments, assisted with community clinics and carried out general administration.

During our inspection we spoke with 13 midwives, five maternity assistants (MAs) and administrative staff, 17 midwives in two focus groups and six women who had recently used the service.

Summary of findings

Overall we rated the maternity (community services) as 'good'.

We saw examples of safety incident reporting systems, audits about safe practice, and compliance with best practice in relation to care and treatment.

Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

The ratio of community midwives to women was 1:120 (one community midwife to each 120 women on their case load), which is above the recommended average of 1:96. A detailed matrix had been used to calculate the ratios and a formal review was planned for June 2016.

We saw examples of good strategic leadership however there were areas where local leadership required improvement.

Patients and their relatives spoke highly of the care they received in the community maternity service.

Maternity (community services)

Are Maternity (community services) safe?

Good

We rated community maternity services good for safe because:

- People were protected from avoidable harm and abuse.
- The trust approach to incident management was timely and enabled a quick and thorough mitigation of the risks relating to the health, safety and welfare of service users.
- Staff told us they were able to raise concerns and were confident their concerns were listened to.
- Safeguarding vulnerable adults and children was given sufficient priority.
- Record keeping was consistent and ongoing risk assessment in pregnancy and the postnatal period was recorded in patient records.
- The named midwife model was in place and women told us they had a named midwife responsible for their antenatal care.
- However, midwives had average caseloads of 120 women. Midwives told us this and sickness rates impacted negatively on the care they could provide to patients.

Incidents

- The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. Risks were identified according to agreed lists of incidents that trigger local review. Escalation of risk was identified through a computer based incident reporting system. Incidents were flagged to clinicians and the executive team. This allowed them to question the clinical teams and review the incident to gather all information.
- Incidents were reported according to the Serious Incident Framework (NHS, March 2015) and staff were able to raise concerns and were confident their concerns were listened to. We saw 318 incidents relating to the community midwifery service were reported between January 2015 and February 2016. Of these, 13 related to low rates of attendance at mandatory training. The home birth team had submitted 62 incident report forms, the Charlotte Road team had submitted 54, the Stratford Road team had submitted 98, the Quinton Lane team had submitted 40 and the Weoley Castle team had submitted 64. Information supplied by the trust did not split the severity of incidents into categories of low, moderate or severe.
- We reviewed the incidents submitted for the community, including the home birth team, between January 2015 and February 2016. The main themes were missed or inadequate newborn screening samples. There were two unplanned births at home.
- We also saw evidence that a pressure sore had been detected by a community midwife following discharge of a patient from hospital and an incident form was submitted. Lessons learned were not available at the time of our visit because the investigation into the incident was ongoing.
- In response to the variation in reporting rates across community teams, champions were identified in each team to support staff, undertake investigations in liaison with the team managers and give teams feedback from incidents and this worked well in practice.
- Staff told us about changes that had been made in response to lessons learned. For example, a checking system had been introduced to ensure all **newborn blood spot** (NBBS) tests (which identify several rare but serious diseases with a small **blood** sample, also called a heel prick test) taken were of the quality required for a reliable test result. We saw all samples were logged and checked by two midwives before being sent for testing. The team leaders were monitoring requests for repeat tests and midwives who regularly failed to take an adequate sample were required to update their skills. Midwives that continued to receive repeat requests were referred to their supervisor. We saw a rolling training programme had been in place throughout 2015 to update midwives in NBBS.
- Other incidents related to neonatal readmissions for jaundice. Readmission of babies was above the nationally accepted average. A review was undertaken and concluded the increase in admissions of babies with neonatal jaundice was most likely to be related to changes in the bilirubin threshold for commencing active treatment with phototherapy following

publication of the 2010 NICE guidelines for neonatal jaundice. We saw that an action plan was in place and was kept under review at the Maternity Clinical Improvement Group (CIG) Clinical Meeting.

- Bilirubinometers (a hand-held device placed briefly on the skin to measure the level of bilirubin which causes jaundice) were provided for community midwives to use to assess jaundice in the newborn. Staff were trained in their use and an algorithm was embedded to jaundice guideline.
- We were told by managers that when necessary women and those close to them were involved in reviews that ensured requirements under the duty of candour were met.
- We saw the home birth team used a 'hot debriefing' tool following a clinical event or incident. This enabled to team to reflect on what went well, what could have been done differently and what needed to be changed.

Safety Thermometer

- The Maternity Safety Thermometer allowed maternity teams to take a 'temperature check' on harm and recorded the proportion of mothers who had experienced harm free care, and also recorded the number of harm(s) associated with maternity care.It was intended for public display so the public were informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from **perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby** and **psychological safety.**It also records babies with an **Apgar score of less than seven at five minutes** and/or those who are **admitted to a neonatal unit. The Apgar score is** an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.
- The trust did not display all the metrics of the national maternity safety thermometer in the community areas and recognised that it was challenging for the community to collect data. This meant that the public could not readily see the risks specific to community maternity care.

Cleanliness, infection control and hygiene

- Personal protective equipment was available for staff in line with trust policy. Midwives carried hand gel for use when hand washing facilities were not available.
- Posters relating to bare below the elbow and hand washing were displayed in all community midwifery offices and midwives adhered to the policy.
- Staff were required to attend mandatory training for infection and prevention control.
- Appropriate advice was provided to women about storing, using and cleaning home birthing pools.

Environment and equipment

- We found equipment was clean and fit for purpose. Electrical safety checks of most equipment we looked at was found to be in date, meaning that it was safe for use.
- We found a sonicaid (a device to listen to a baby's heartbeat) that did not have a service sticker on, and the midwife did not know when it was due for servicing. We raised this with the team leader who arranged for immediate testing of the equipment.
- A 'grab bag' containing resuscitation equipment was available for use at home births. We saw there was a checklist for home birth equipment and it was checked daily so the equipment was ready for use.

Medicines

- 'Healthy Start' is a UK-wide government scheme to improve the health of low-income pregnant women and families with young children on benefits and tax credits. As part of the scheme, women may be given vitamins. We saw boxes of vitamins were stored in boxes in the Weoley Castle Team office. This meant that medicines were not securely stored and could be tampered with.
- We were told that maternity support workers gave the vitamins to women at their first scan appointment and made a record in the patient's hand held record to support this.
- Other medicines across all four community teams were safely and securely stored. The community midwives and home birth team did not use controlled drugs.
- All allergies were clearly documented in women's notes.
- Temperatures of refrigerators used to store medicines in the home birth team office were monitored and recorded daily to ensure medicines were stored correctly and women and babies were not at risk of the administration of ineffective medicines.

- Pre-prepared packs were provided for the home birth team midwives by pharmacy containing Syntometrine, Ergometrine (medicines used to make the uterus contract and prevent bleeding after birth) and Vitamin K (given to new-born babies to help with clotting of the blood). The home birth team took the pack with them when attending a home birth.

Records

- We reviewed five sets of postnatal maternity records.
- The trust used paper based patient records and these were securely stored in each community office we inspected.
- Records were transported appropriately and returned promptly to the community midwives office for collation with hospital records. An audit system was in place to ensure all records were returned in order to support ongoing care and multidisciplinary team working.
- A 'child health record' ('red book') was issued to mothers on discharge from hospital and used appropriately to transfer a record of the child's health, growth and development to the health visiting service.
- Documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Risk assessments were in place and reviewed throughout a woman's pregnancy. Care plans contained clear accounts of actions taken to reduce and manage risks to patient safety.
- Midwives kept files containing demographic details and records of antenatal visits of women on their caseload. We saw some of these records were badly organised with old and new completed caseload lists. This meant it could be difficult for another midwife to cover in times of holiday or sickness.
- Patient's confidentiality was protected because the laptops used by community midwives had secure access, were encrypted, and could be shut down by the information technology department if stolen.
- Old diaries were securely stored at some of the bases ie Charlotte Road and Quinton Lane but not at other community midwifery bases. Community midwives did not routinely send old diaries to the hospital site for storage.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and national and local policy.
- Each team had a safeguarding champion who liaised with the safeguarding lead and reported back to the team at team meetings.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- Midwives and maternity assistants (MA) had access to level three safeguarding children training in line with the intercollegiate document (2015). Updates at level three were provided annually on the mandatory training programme. Safeguarding training compliance at level three was recorded at 92% compared to the trust target of 85%.
- Safeguarding training included safeguarding people at risk of and to treat those affected by female genital mutilation (FGM). All staff working with women and babies affected or at risk of FGM were required to complete the FGM e-module developed by Health Education England. The FGM specialist midwife position was being advertised at the time of our visit and a midwife from a neighbouring trust was working on a sessional basis to cover the FGM service in the meantime.
- There were systems in place to monitor the disclosure of Domestic Abuse by midwifery staff in line with NICE guideline (PH50) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded.
- The Family Common Assessment Framework (fCAF) is a multi-agency approach to identify and assess the safeguarding needs of parents and children, including unborn children, and work out the best response. This meant all services working with families used the same method for initially assessing children and understanding their needs. Community midwives attended training on fCAF provided by Birmingham City Council.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). Effective supervision is important to promote good standards of practice and to support individual staff members.

- Community midwives had quarterly supervision. We saw documentary evidence that there were two safeguarding supervisors in the community and a programme of supervisory sessions scheduled twice a month from April 2016. We spoke with staff about the provision of safeguarding supervision. We were told the trust did not provide this and there were plans to roll out safeguarding supervision for community midwives in the autumn. We were not assured the staff understood or knew about the function of safeguarding supervision and their requirement to attend for ongoing support with safeguarding.
- An externally funded team of midwives, the enhanced team, provided targeted care for the most vulnerable women in the community.

Mandatory training

- Trust mandatory and maternity specific training and other learning and development was managed by the team leaders this included; maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Team managers advised that mandatory training was arranged in a block to enable staff to complete it all in one week, facilitating easier compliance. The trust provided the block schedule for 2015 and 2016 to the inspectors. One team manager showed us a schedule of mandatory training posted on the team's information board. Attendance at mandatory training was reported as incidents when the target of 85% was not achieved. We saw documentary evidence that showed the Charlotte Road team was 90% compliant, the Home Birth Team achieved 89.9% and the other three teams fall just short of the target at 84.2% (Stratford Road), 84.3% (Quinton Lane) and 84.7% (Weoley Castle).
- The content of the maternity specific study days were changed annually to reflect incidents that had taken place. For example, training sessions on new-born blood spot screening training was now mandatory and completed annually because of higher than expected requests for repeat tests.
- The maternity skills study day used community-based scenarios. These provided community midwives with the opportunity to practise emergency skills and drills in settings appropriate to their area of practice.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse.

Assessing and responding to patient risk

- For women using maternity services the booking visit took place before 12 weeks of pregnancy. This included detailed obstetric, medical, mental health and social risk assessments. An initial maternity booking and referral form was completed by community midwives at the booking visit. Between April and December 2015 96% of women were seen by a midwife by 12 weeks and six days gestation of pregnancy.
- Community midwives referred women with identified risks at the booking visit for obstetric review and onward pregnancy planning. Problems identified throughout were also referred for obstetric review on the Day Assessment Unit (DAU). If required they were admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant women could be referred for further scans and plans made for their pregnancy.
- The fetal Gestation Related Optimal Weight (GROW) charts were customised antenatal charts for plotting height and estimated fetal weight. GROW charts were in use to help identify babies who were not growing as well as expected. This meant women were referred for further scans and plans made for their pregnancy when required.
- Failure to provide mandatory GROW training necessary to enable staff to detect issues of intrauterine growth restriction or tailing off fetal growth was on the risk register. To mitigate this risk, training was provided and we saw GROW updates were included in the annual mandatory maternity specific training programme.
- The trust told us the CCG no longer commissioned smoking cessation or nutritional support for women

with raised body mass indices (BMI) services. The trust was in the process of mitigating this and an independent company had been contracted to provide healthy living support from June 2016.

- Women were offered vaccinations against influenza and whooping cough.
- **The guidelines for management of sepsis in the obstetric patient required any woman who appeared unwell should have a full history taken, be examined using the ABCDE (**Airway, Breathing, Circulation, Disability, and Exposure) approach **and that observations should be documented on a Modified Early Obstetric Warning Score (MEOWS) chart. We reviewed ten sets of records and found two women who had suspected uterine infections in the postnatal period. Observations of vital signs were not recorded and the midwife in both cases told the woman to visit her GP.**
- There was a Did Not Attend (DNA) policy the trust adhered to. A letter was sent to the woman's GP by the administrative staff if a woman missed an appointment, community midwives were alerted and visited homes if necessary. This meant staff were aware of women who had missed appointments and could arrange follow up to ensure they attended for care and raised safeguarding concerns when they did not do so.
- We saw women planning a home birth were risk assessed at 36 weeks of pregnancy and when in labour risk assess for home birth. The trust had a transfer policy for women birthing at home, or newborn babies, who required medical attention in hospital.

Midwifery staffing

- There were 53.86 whole time equivalent (WTE) midwives and 2.6 WTE maternity assistants (MAs) in post.
- Senior management told us the Charlotte Road team required 13.39 WTE midwives and there were 10.6 WTE in post. Quinton Lane team required 13.7 WTE midwives which were in post. Stratford Road team required15.5 WTE midwives and there were 12.7 WTE in post. The Weoley Castle team required 17.3 WTE midwives and there were 14.2 WTE in post.
- The home birth team was funded separately for 5.8 WTE midwives and 4.6 WTE MA's. At the time of our visit there were 3.4 WTE midwives and recruitment was ongoing. The midwives worked 12 hour shifts and two were on call each night. A MA was also on call to attend home births.
- There was a vacancy factor of 5.93% and sickness rate of 6% across the community teams; the sickness rate varied between 3% and 12% across the teams.
- Caseloads were GP attached and arranged by the number of women in each surgery and according to the complexity of the needs of the women. The Head of Midwifery (HoM) used a matrix to calculate required caseload numbers based on skill mix, professional judgement, metrics and birth rate plus that suggested that average case load of 120 women was appropriate for staffing levels to enable the delivery a safe level of service.
- We were told that midwives' caseloads varied within each team and across the community as a whole. We were told that caseloads varied between 120 and 150. Two midwives working a total of 1.6 WTE hours told us that they shared a caseload of 205.
- The impact of this was they found it difficult to book women by ten weeks of pregnancy; postnatal care was not compromised and the day five visit (when the baby is weighed and screening tests are taken) could be done by another midwife, although this affected continuity of care as the woman was not seen by her named midwife, checks were still being carried out.
- Community midwives undertook safeguarding activities in their own time, for example, we saw a message in the communications book at the Weoley Castle team office requesting cover for a care group meeting for an unborn baby which demonstrated no one was able to attend.
- Staff we spoke with expressed concern that caseloads were going to be increased from 110 to120. Team leaders were allocated two management days per week and also carried caseloads of 80 women. There was one band five midwife attached to each team as part of the preceptorship programme; band five midwives did not have a caseload.
- Senior community managers had raised this issue and it was added a new risk to the risk register in March 2016. This meant the trust regularly monitored community caseloads to review and revise midwives' caseloads.
- Community midwives undertook an average of five shifts per month on the Birth Centre; this was included in their duty rotas.

Maternity (community services)

- A bank of temporary staff which was made up of permanent staff undertook extra work to cover shortfalls. The Charlotte Road team had used six bank shifts in the two week period prior to our inspection to cover shortfalls. Quinton Lane team was three midwives short for the week following our visit: bank shifts had been arranged to cover this shortfall. The Stratford Road team was four WTE short the week following our visit.
- One consequence of long term sick was limited back fill was available and team leaders gave examples of only being able to cover one day out of three. This led to delays in booking women and impacted negatively on continuity of care because women were not booked by their named midwife.
- Recruitment had been frozen due to a trust-wide directive. However, the trust was recruiting at the time of our visit and had agreement from the board to over recruit. This meant there would not be shortfalls when existing staff left the organisation.
- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- A Birthrate Plus® recommendation is that community midwives have caseloads of 1:96. In order to understand community workload better and for a full system review we were told the planned Birthrate plus review will be brought forward to ensure staffing and data was correct.
- The MAs supported the midwifery teams by undertaking phlebotomy (taking blood samples), supporting scan clinics, preparing notes and maintaining stock levels.
- We spoke to a member of staff who had been waiting to change teams to utilise their skills fully. However, this was delayed because the existing team was short of support staff.
- There was a lone worker policy which community midwives adhered to. Lone working was on the risk register because of the shortage of alert devices however, these had been ordered. To mitigate the risk a safety tool was used, for example, a midwife was responsible on a daily basis in each team for the lone worker log. Midwives provided the addresses they were visiting and attendance was checked against the list of those on duty for the day. If they were delayed, the allocated midwife would telephone or text them to enquire about their whereabouts. If they could not be located the next of kin was contacted and the situation escalated to the manager on call. We asked to see records of this and were told they were destroyed after each shift. We saw from minutes of team meetings the log may be destroyed through the confidential waste system the following day.

Major incident awareness and training

- There was a leaflet for staff informing them of their responsibilities in the case of a major incident and staff knew what action to take in the event of adverse weather conditions.

Are Maternity (community services) effective?

(for example, treatment is effective)

Not sufficient evidence to rate

- Care and treatment reflected current evidence-based guidance.
- Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care.
- Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working. Staff worked together to serve the interests of women across hospital and community settings.
- Midwives from the home birth team were on call 24 hours a day to facilitate the homebirth service. Access to medical support was available seven days a week and a transfer policy was in place.

Evidence-based care and treatment

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet. The use of hard copies was not encouraged to ensure staff were using the most up to date guidance, policies and procedures.

Maternity (community services)

- The care of women using the maternity services was in line with the Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- Care was provided in line with the NICE Quality Standard 62. This quality standard covers the antenatal care of pregnant women with straightforward pregnancies up to 42weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- Homebirth was offered by a designated team as part of a pilot scheme commissioned by the CCG. The aim of the pilot scheme was to increase the home birth rate from 0.3% to 3% in 3 years. The study was at the beginning of its third year at the time of our visit. Women typically transferred to the team after their 20 week scan. They had all their antenatal and postnatal care provided at home and midwives attended them for birth over a 24 hour period.
- We saw that the number of home births was kept under review at the Maternity Clinical Improvement Group Meeting (CIG) and entered onto the maternity dashboard. A challenge to the home birth team was working to meet the target of 1% increase per year. Documentary evidence showed in year two, there were 140 births at home by January 2016 compared to the target of 212 births for the year. This was on the risk register and had been discussed at the Service Development & Improvement Plan (**SDIP**) meeting held in December 2015 and an action plan had been developed.
- Choice was offered to women in relation to all aspects of maternity care including screening and place of birth. The Trust offers to patients the use of an electronic application (App) to facilitate informed choice regarding place of birth and is working with Birmingham University to develop a place of birth discussion tool.
- The trust offered screening in line with the National Screening Committee (NSC) recommendations. Patients were supported to make decisions around screening and were provided with the NSC leaflet at booking. We saw documentary evidence to show that the 10 week key performance indicator (KPI) for haemoglobinopathy screening was 30% compared to the target of 50% in December 2015. This was on the risk register. Additional phlebotomy clinics were introduced to increase capacity to undertake the test.
- Women were offered screening for Down's, Edwards' and Patau's syndromes (rare genetic conditions that affect babies) between 10 and 20 weeks of pregnancy. To ensure quick and accurate test results, essential information must be provided on the test request form. The proportion of completed laboratory request forms submitted to the laboratory within the recommended timeframe was audited by the National Screening Committee. We saw the trust was 94.6% compliant compared to the national target of 97% between June 2015 and September 2015.
- Women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, and care of their new born baby. Evidence indicated NICE Quality Standard 37 guidance was being adhered to in respect of postnatal care. This included the care and support every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- The NHS **newborn blood spot** screening programme helps identify several rare but serious diseases with a small **blood** sample, also called a heel prick test. NHS Guidelines for Newborn Blood Spot Sampling (NBBS) provide a consistent and clear approach to NBBS. The trust was not always meeting the target for the KPI for avoidable repeats which was 2%. This meant babies had to have the test repeated which causes distress to babies and their families.
- A checking system had been introduced to ensure all tests taken were of the quality required for a reliable test result. We saw all samples were logged and checked by two midwives before being sent for testing. The team leaders were monitoring the requests for repeat tests and midwives who regularly failed to take an adequate sample were required to update their skills. We saw a rolling training programme had been in place throughout 2015 to update midwives in NBBS.

Maternity (community services)

- Care was provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Pain relief

- Discussion on options for pain relief formed part of the birth plan discussion at 36 weeks.
- An external company delivered Entonox (a gas used for pain relief in labour) to the homes of women birthing at home.The midwives called the company when they were aware a woman was in labour and gasses and emergency resuscitation equipment was delivered to the home with information as to how to store them. Women who wanted to use water immersion for pain relief in labour were advised on how to obtain a pool for use at home.

Nutrition and hydration

- An Infant Feeding Co-ordinator was responsible for infant feeding in maternity. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- < >supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and their baby.In October 2015 the commissioners issued the trust with a contract query because the required threshold of 75% for breastfeeding had not been achieved for three consecutive months. In response, a breastfeeding action plan was developed by the HoM and the Infant Feeding Co-ordinator. As part of this work an audit exercise was undertaken to look at the records of babies whose original feeding was not breast milk. The audit identified some babies did receive breast milk. As a result an audit of records was included in the reporting on breastfeeding rates.
- We saw the breastfeeding rate on discharge from the hospital was 74.9% in 2015 which was similar to the national average of 75%. Statistics were not kept for the breastfeeding rate on discharge from the maternity services.
- The breastfeeding initiation rate for the home birth team was 85%. On discharge from the maternity services, the breastfeeding rate for the home birth team was 79%.
- Babies with tongue tie (a condition where the string of tissue between the baby's tongue and floor of the mouth is too short and affects the baby's ability to latch onto the breast causing feeding problems) could be referred to midwives trained to divide the tongue tie if required. This meant women and babies received timely intervention when feeding was complicated by tongue tie.

Patient outcomes

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The Maternity Dashboard served as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so timely and appropriate action can be started to ensure woman-centred, high-quality and safe maternity care.
- The number of women booked before 12 weeks gestation in December 2015 was 95% which was above the trust target of 90%. The trust capped the number of bookings in order to ensure safe care could be provided to women throughout their pregnancy, birth and postnatal period.
- Smoking rates in pregnancy were 4.5% in December 2015 compared to 12% of mothers who were recorded as smokers at the time of delivery for 2013-14. The trust told us the smoking cessation service had been decommissioned and plans were being explored to manage this.
- Community midwives had undertaken 4745 antenatal contacts and 1820 postnatal contacts in November 2015.

- There were 364 women who booked with the home birth team between April 2015 and March 2016. A total of 112 women started labour at home, of these 98 birthed at home.
- There was a 22% transfer rate of which 15% were intrapartum transfers and 7% were postnatal transfers.
- We saw documentary evidence that 69% of women birthing at home used water for pain relief and 46% had a water-birth.

Audit

- Community midwifery teams contributed to local audit to improve the service offered to women.
- We saw evidence that the uptake of membrane sweeps with the aim of avoiding formal induction of labour was audited. **membrane sweep**guideline CG70: Inducing Labour. BWNFT local guidelines states all women should be offered a membrane sweep at 40 and 41 weeks to reduce the need for induction of labour
- We saw 72% of women were offered a membrane sweep at 40 weeks and 81% were performed at 40 weeks. The audit showed 71% of women were offered a membrane sweep at 41 weeks and 79% were performed at 41 weeks. In both cases the majority of the sweeps were carried out by the community midwives (77% and 67% respectively).
- The audit also evaluated the use of the membrane sweep proforma. The compliance rates for the community midwives were 67% (20/30) at 40 weeks and 56% (10/18) at 41 weeks.
- Recommendations including highlighting the importance of membrane sweeping to aid the reduction of formal IOL and ensuring adequate stock of membrane sweep proformas in community offices were made and an action plan drawn up with allocated responsibilities and review dates set.
- Ongoing audit of the home birth pilot scheme took place and was reported to the commissioners. An external formal evaluation was planned at the end of the pilot.

Competent staff

- An induction period of two weeks was offered to newly appointed staff. In addition, all newly qualified midwives undertook a nine month preceptorship period prior to obtaining a band six position, which included rotation in the community. This meant they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- Appraisal rates for staff demonstrated 95% of midwives had been appraised. We saw documentary evidence of appraisal schedules, with review dates documented. The team manager discussed mandatory training and other learning needs at appraisals.
- Staff within the teams reported they had development opportunities, such as three of the team leaders were currently accessing leadership courses and other staff members reported attendance at national conferences as well as seven MAs undergoing a foundation degree.
- We were told community midwives and the home birth midwives who were qualified in newborn and infant physical examination (NIPE) carried out examinations of babies.
- We observed some midwives were trained to undertake ultra sound scans in community clinics. This was a feature of the service development going forward.
- MAs working with the home birth team were encouraged to undertake a two year Foundation Degree programme. This prepared MAs to support the service by being the second at home births, carrying out NBBS tests, weighing babies and providing breast feeding support.
- We spoke with MAs who felt they could offer the same level of support to the community teams but was prohibited from doing so by the team leader. Senior management confirmed all MAs could undertake delegated roles, such as carrying out NBBS tests, weighing babies and providing breast feeding support, provided they had been trained to do so. This meant that skill mix was not utilised fully to support the delivery of care to mothers and babies, particularly in the postnatal period.
- The function of statutory supervision of midwives is to ensure safe and high quality midwifery care is provided to women. The nursing and midwifery council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs)

were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.

- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw the SoM ratio was 1:17 which meant there were not enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice. The need to train more SoMs was dependent upon forthcoming consultation on the future of midwifery regulation which will remove this statutory requirement.
- Midwives reported having access to and support from a SoM 24 hours a day, seven days a week and knew how to contact the on-call SoM.

Multidisciplinary working

- There was good multidisciplinary working across all the maternity services that facilitated easy and timely referral.
- The hospital informed community midwives and GPs when a woman had suffered a pregnancy loss. However, we saw documentary evidence that a patient had contacted the bereavement office to say she had received a text message reminding her of a forthcoming antenatal appointment.
- There was effective multidisciplinary team work between community midwives, health visitors, GPs and social services. Midwives had monthly communication with Health Visitors to discuss the care of women on their caseloads.
- Community midwives were able to make direct referral to an obstetric physiotherapist which meant that women received treatment in a timely manner.
- There were links between the community and hospital midwifery teams. Team leaders attended a weekly meeting and information was cascaded to midwives via email.
- We saw a multi-agency event, 'Improving the Health of Birmingham's Women and Children,' was held in July 2015 to raise awareness of local services, increase partnership working and promote inter-professional education and knowledge sharing. Topics discussed included: perinatal mental health, 'Healthy Start Programme', safeguarding, Doula Project, infant feeding and tongue tie and hypnobirthing. There were forty five delegates in attendance, thirty one of whom completed an evaluation form: 71% rated the day as 'excellent' and 29% as 'good'.

Seven-day services

- Community midwives were available seven days a week. Out of hours antenatal patients had access to a 24-hour triage unit at the hospital. Postnatal patients were advised to call their GP.
- Patients could also contact their midwife by telephone or leave a message, which was returned the same day.
- A communication book was used to convey messages within teams. For example we saw a request for colleagues to follow up on a swab result whilst a midwife was on days off. This had been dated and signed to indicate that it had been actioned.
- An on-call rota was in operation for the home birth team to cover home birth, supported by community midwives. This meant that women could be confident enough midwives were on duty at any one time to facilitate birth at home.
- The on call midwives also attended unexpected births at home born before admission (BBA).

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides, policies and procedures to assist in their specific role.
- In addition, community midwives had laptops which meant they were able to obtain blood results and other information easily. In addition, they could access information from the GP system when in clinics at the surgeries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff showed the appropriate skills and knowledge in seeking consent from patients. They were clear about how they should seek verbal informed consent or written consent before providing care or treatment.
- Training on the MCA and DoLS was included in safeguarding training. Staff understood the legal

Maternity (community services)

requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The trust had issued staff with cards outlining their duties and professional obligations relating to the Act.

Are Maternity (community services) caring?

Good

We rated community maternity services as good for caring because,

- Feedback from patients and those close to them was positive. Patients told us they felt safe. Staff treated patients with dignity, respect and kindness during all interactions.
- Patients were involved and encouraged to be partners in their care and were supported in making decisions. Patients told us they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.
- Community staff responded compassionately when patients needed help and supported them and their babies to meet their personal needs.
- Community staff helped patients and those close to them to cope emotionally with their care and treatment.

However, we also saw;

- The NHS Friends and Family Test (FFT) responses were so low they could not report on them.

Compassionate care

- The community maternity service was delivered by committed and compassionate staff. Patients were treated with dignity and respect.
- Maternity services were added to the NHS Friends and Family Test (FFT) in October 2013. The postnatal care in the community question related to the community service. In response to the question 'How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment?', the trust report showed that for the months of April to September 2015 the response rate figures were so low they could not report on them. The trust made significant improvement after this, with a figure of 100% for the months of October to December 2015. However, it is important to note the response rate was low. For example, the community had 15 responses in October 2015 and 30 responses in November 2015. The homebirth team had one response in October 2015 and two in November 2015.
- Staff in all community teams said that they administered the friends and family test; however staff advised us this was not done particularly well in some cases. One staff member told us their team only gave out two -three per month until recently with an improvement of 20 per month over the last few months; this was supported by an audit from the trust. Conversely, another staff member advised us they gave one to every family which was corroborated by a student who attended the majority of appointments with the midwife.
- We saw a selection of thank you cards in the home birth team office from patients and families expressing appreciation for the care they received.
- Patients we spoke with were positive about the care that had received. One woman told us she was "quite amazed" by the service she had received. She described her midwife as "very kind, someone I would like at my delivery."

Understanding and involvement of patients and those close to them

- Patients and those close to them were included when deciding on their care and treatment plans.
- Women told us that diagnostic terms were explained to them and choices were given as to available birth settings that are appropriate and safe for their clinical need and risk.
- Women were active partners in their care and their wishes where taken into account by staff providing the service.

Emotional support

- Women expressed appreciation for the emotional support they received from the staff. One woman told us "I had lots of emotional support, time was not an issue."
- Another told us problems were detected with her baby before birth, "the issues were addressed quickly and compassionately and I was dealt with very kindly."

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- Midwives carried out assessments for anxiety and depression during pregnancy. Community midwives could refer women to the specialist midwife in mental health for additional support.
- An 'afterthoughts' service was available. This allowed women to discuss concerns about the care they received during and after their pregnancy. The trust told us this had been well received by women.

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

Good

We rated community maternity services as good for responsive because:

- Patients' needs were met through the way services were organised and delivered. The trust worked with local services, such as Children's Centres, to deliver maternity care in the community.
- Post-natal follow up care was arranged well as part of the discharge process from hospital.
- Individual needs were considered in the provision of care and help was provided to people who did not have English as a first language in a variety of ways including the use of interpreters and video books.
- There was a specialist midwifery team for vulnerable women which comprised of a specialist midwife in mental health, substance misuse, teenage pregnancy and female genital mutilation.
- Patient complaints and concerns were always listened to compassionately, dealt with promptly and duty of candour was observed.
- We saw evidence the duty of candour was observed, the complainants had been contacted, invited for a meeting and we saw letters of apology,

Service planning and delivery to meet the needs of local people

- It is best practice that women access maternity services directly. A standard operating procedure (SOP) was in place for access to the service. Women could access the maternity services via their GP.
- Post-natal follow up care was arranged as part of the discharge process from hospital. Details of women discharged from hospital were faxed daily to the team and an allocated midwife entered visits into the team diary so community midwives knew who to visit each day. The red book, issued in the hospital, was completed as required to facilitate on-going care and monitoring of the baby until five years of age.
- However, we noted that there were four instances of the community midwives being unaware of women discharged from other hospitals in the area. The trust has confirmed that there is a standard operating procedure to ensure that all women discharged from hospital are referred to the community midwife. Each referral letter is collected from the GP surgery by the midwife. All women who have registered a birth are entered into a book at the GP surgery. The midwife and GP receptionist check the referral letters against the book.
- The service had implemented a named midwife model of care. Women confirmed they had a named midwife and valued the continuity of care this provided.
- The trust had an enhanced team in place to care for women with complex social needs.
- Scans were offered in community clinics. Women valued this service because they did not have to go to the hospital and could access the service closer to home.
- The maternity management team proposed a new model of care, which involved reconfiguration of the community service, to trust board. This model would reflect the maternity unit's approach to evidence based, women centred maternity services.

Access and flow

- Women accessed the service via their GPs. Midwives were attached to GP practices and collected referral letters. The referral was entered into the caseload file for the surgery and filed according to the estimated due date. Community midwives obtained a list of all pregnant women at each surgery on a fortnightly basis and checked all referrals had been checked and each woman was receiving care against the caseload file. In some cases, the woman contacted the midwife directly who then made the referral.

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- An appointment was made for the booking visit with a named midwife at home. This was the first meeting with a midwife where a medical history was taken, risks were assessed, scans arranged and plans made for the pregnancy.
- Women were also sent appointments to attend a community clinic for blood tests and for scans.
- We saw women were risk assessed at booking and low risk women defaulted to a low risk pathway. The Charlotte Road team was working with the home birth team. Following risk assessment, second and subsequent mothers with straightforward pregnancies were defaulted to the home birth team for discussion on home birth and ongoing care.
- Women could access the homebirth team directly. Management told us women tended to transfer to the home birth team after the 20 week scan. Women had a named midwife and were offered continuity of care via a team approach.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place of birth at 16 weeks.
- Details of women discharged from hospital were faxed daily to the team and an allocated midwife entered visits into the team diary so that community midwives knew who to visit each day. The red book, issued in the hospital, was completed as required to facilitate on-going care and monitoring of the baby until five years of age.
- Women were seen at least three times in the postnatal period: on discharge home, day five and on discharge to the health visitor around 10 to 14 days after birth. Women who required additional midwifery care were offered appointments or visited according to their needs.
- Women were offered the choice of home visits or appointment at postnatal clinics (which are frequently offered in maternity services). Once a midwife had seen a woman, the next visit was entered into the diary. This meant women received postnatal visits.

Meeting people's individual needs

- We saw a variety of patient information leaflets. Women had access to the Birmingham Women's App which provided them with information about the service.
- A leaflet and video on home birth was available on the trust website for women who wanted more information about having a baby at home.
- We saw there was an interpreter service available by telephone. Staff told us interpreters routinely attended some clinics where the majority of women did not speak English as a second language. Interpreters were booked for specific appointments and would accompany the midwife to the home if required.
- Parent education classes were available at local children's centres and booked on line. The home birth team also ran bookable 'Meet the Homebirth Team' sessions where women could ask questions and discover the family-centred approach the Homebirth Team takes to care.
- There was a specialist midwifery team for vulnerable women which comprised of a specialist midwife in mental health, substance misuse, teenage pregnancy and female genital mutilation.
- We saw a video book was available in a variety of languages and available for women in the clinics.
- Women who chose to birth at home against midwifery and medical advice were supported by the home birth team. A birth plan setting out the recommendations, plans for mitigation of potential problems and an explanation of when it would be necessary to transfer to hospital was made in conjunction with a SoM and filed in the hand held notes. Two midwives were present at such births.
- Community midwives worked with the Bethel Doula Service to provide support to refugees and those seeking asylum.
- We saw the trust used specific notes for patients with learning disabilities. These notes had larger print and were illustrated to help patients understand.
- The home birth team were on-call to facilitate home birth over a 24-hour period, seven days a week. The community midwives provided additional support if required.

Learning from complaints and concerns

- Complaints were managed by the trust wide Patient Experience Team. If a woman or relative wanted to make informal complaints, they would be directed to the team manager, matron or the Patient Experience Team.
- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns

Maternity (community services)

or make complaints. Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days. Complaints were kept under review at the Maternity CIG Clinical Meetings.

- We saw there were three complaints regarding the community midwifery service in 2015. Of these, one was open and the family were in dialogue with the Head of Midwifery (HoM). We discussed learning from complaints with the management team who told us care issues, communication and staff attitude were common themes.
- Information from the trust indicated there had been 10 maternity complaints, two of which were formal complaints made between October and December 2015.
- We saw evidence the duty of candour was observed, the complainant had been contacted, invited for a meeting and we saw letters of apology.

Are Maternity (community services) well-led?

Good

We rated community maternity services as good for well led because:

- There was good staff engagement and an active Maternity Service Liaison Committee that provided feedback to the service.
- Clear evidence of vision and strategy for the future of the service.
- The Community Maternity risk register reflected current risks and risks were reviewed on a regular basis.
- The team mangers held regular team meetings with their teams to discuss issues, feedback from managers, staffing, clinical incidents, information relating to the risk register and general local matters.
- There was an active Maternity Service Liaison Committee that provided feedback to the service.
- BWHFT were awarded a Service Development and Improvement Plan (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service.

However we also saw,

- The community team leaders were not represented at directorate meetings. The teams demonstrated varying levels of effective leadership.

Vision and strategy for this service

- The maternity service had a clear vision for the future. A draft 'model of care' overview paper and the supporting strategy document underpinning the vision supported this.
- The HoM had mapped pathways and identified hot spots. The inspectors did not see the mapping document; however this was related to past strategy for the trust. The first three years had focused on operational issues particularly around staffing, training, and support roles.
- The next step was to focus on the community maternity service. The vision was to move care into the community with the aim that 30% of women birthing at Birmingham Women's Hospital would be cared for in the community. The HoM and her team planned to develop the service on demographics and service delivery. The plans included care based in hubs around the community, developing the midwife sonographer role and the MA role.
- The HoM had prepared a draft document for presentation to the next executive team meeting. This had been shared with the commissioners.
- She described the plan to move sonography into the community; however, they were not aware of the plan to develop the MA role.
- The National Maternity Review published its final report on 23 February 2016, setting out recommendations for the future shape of modern, high quality and sustainable maternity services across the NHS in England. The trust had applied for funding to become one of the **Maternity Choice and Personalisation Pioneers, in the first stage of implementing the recommendations from the National Maternity Review.**

Governance, risk management and quality measurement

- The community matron participated in the Maternity CIG Clinical Meetings. They described a system where they would raise issues with the HoM and gave an example of this. This involved the plan to address the

lack of sonographers, which the trust had highlighted within the outpatients service. The trust had a plan to develop sonography in the community, however due to staffing issues currently existing within community services this would pose a risk to existing services. Senior community management was aware that the HoM discussed governance issues at a higher level after the Maternity CIG Clinical Meetings but was unsure of the exact pathway for this.

- We reviewed the minutes of the Maternity CIG Clinical Meetings from November and December 2015 and January 2016 and saw it followed a standing agenda. Issues were identified and actions were planned and reviewed. We noted community team managers did not attend the meetings as senior leaders did not invite them, an action on the January minutes was to invite them to future meetings. Team managers were beginning to attend the meetings but the uptake was slow.
- The community matron met with the team managers weekly, who then met with their teams. The trust provided evidence of this with minutes of the maternity managers meeting and community team meeting minutes. We saw the same information, for example, the uptake of Information Governance e-learning was discussed at the managers meeting and was fed back to staff in their meeting. Another example was recruitment of a midwife to the Quinton Road team which was mirrored in both meetings.
- The team mangers held regular team meetings with their teams to discuss issues, feedback from managers, staffing, clinical incidents, information relating to the risk register and general local matters such as the duty rota and cover arrangements. We reviewed the minutes of each team meeting for February, March and April 2016 and saw attendance was recorded, issues were discussed and actions were planned.
- Minutes of the Antenatal Group meeting for September and October 2015 showed there was an agenda item entitled Clinical Issues/Feedback From Areas it was noted 'Community: No representative present, so deferred.'. This was due to lack of capacity within the teams to send a member of staff.
- We saw the maternity risk register had six risks that affected the community service. Of these, three were rated as high risk, one as moderate and two as low risk.
- The high risks included the impact on clinical services following change to neonatal jaundice guidance, failure to achieve the antenatal sickle cell and thalassaemia screening target prior to ten weeks of pregnancy and lack of referrals to the homebirth team. Action plans were in place, supported by appropriate mitigation and all items were due for review in February 2016.
- The moderate risk was failure to provide mandatory GROW training. This item was due for review in February 2016.
- The low risks were higher than planned maternity activity cap bookings review April 2016 and risk of violence and aggression to lone workers. These were due for review in April 2016.
- The community matron attended the monthly directorate risk management meetings. We reviewed the minutes of the meeting for October and November 2015 and January 2016 and saw risks were described, actions were decided upon, responsibility allocated and deadlines for review set.
- The home birth team used a 'Hot debriefing' tool weekly to discuss cases and look at issues. This enabled sharing of outcomes from the directorate risk management meetings.
- There was a mixed response among community team managers regarding clinical audit. One of the team mangers was able to give detailed information of clinical audit undertaken. Three of the team managers advised that the teams did not run the clinical audit themselves, but took part in collecting the data. The clinical audit department ran the audit programme.
- Guidelines were kept under review by the Maternity CIG Clinical Group. The trust provided the inspectors with the minutes of six monthly CIG meetings which clearly showed the conversations, actions and governance processes. We also saw a list of the latest guidelines were displayed on notice boards in community midwives' offices to alert them to updated guidelines. The trust provided the inspectors with an example of a guideline that demonstrated accountable leadership, multi-disciplinary and inter agency working. This was the Handover of Care and Transfer Guidelines for Maternity Issue Date: 24/02/2016. The inspectors could clearly see the governance arrangements, the route for dissemination of the guideline and the evidence which supported its development. It was also clear to see the triggers for incident reporting and supporting surveillance documentation were included in the document

Maternity (community services)

Leadership of service

- The HoM supported the Matron well with regular monthly meetings and we observed good interaction between them. Both talked passionately and consistently regarding the vision for the new model of care and appeared to be cohesive in their approach, both outlining the benefits of the new model and how they had worked together to put together the strategy document.
- The team managers reported the matron supported them well with regular meetings and an open door policy. The matron and team managers had one to one sessions where they discussed specific issues and worked to resolve them. The Matron supported the team managers to undertake leadership training in response to identifying leadership as a leaning need.
- Midwifery staff spoke positively about the matron. There were good examples of leadership and teamwork at team level.
- In addition, other examples of good senior leadership were demonstrated such as the relationship with Heartlands Hospital who helped to cover the FGM service.
- The team managers had two protected management days per week, and they were only occasionally required to deliver clinical care on these days. Three of the team managers provided evidence of the management days scheduled in the staff duty rota.
- The community matron sent communication from the hospital via emails. All community midwives had a laptop. One team leader told us she sent emails onto her team but they had asked her for verbal updates. However, staff told us that they found changes out 'by chance'. For example the midwives in one team were not aware of the change of protocol for Glucose tolerance tests (GTT) and were unaware the trust was no longer offering screening for rubella, which had become the responsibility of the GP.

Culture within the service

- Some low morale was evident and we were told isolated allegations of discrimination from staff had not been managed effectively by senior community midwifery managers . Senior managers had not responded quickly to concerns raised by staff. Staff estimated issues being ongoing for more than six months prior to any intervention. In addition, staff told us they were not supported to develop and they had tried to raise issues but had not been listened to. This indicated there was an unhealthy culture which did not promote effective listening and management of staff's concerns.
- There was a mixed response from staff regarding the effectiveness of the actions taken. For example, staff said some of the issues for discussion that had been put anonymously into a feedback box were not addressed and they felt there was 'still no point in raising issues'. Some staff reported changes for the better, for example, had better support for each other when caseloads were heavy, whilst others stated certain issues had still not been addressed and some staff were still unhappy.
- We raised this with the Matron who advised us she was aware of the situation and ongoing support was being provided.
- Staff reported in one team they did not have a manager for more than 18 months and although the Matron was supportive and helped where possible they felt they were left to "get on with it." One of the impacts of this was that staff worked more than their hours and accumulated significant time owing, which was not managed effectively until the return of the team manager. The impact of this was staff then took significant time owing, affecting availability of midwife time.
- Staff reported feeling a little isolated from the main hospital, however said the team meetings helped.
- Staff spoke positively about the service they provided for patients. They worked well together within their teams and felt that they would and could continue to develop and improve services in the future.
- Staff were mostly content in their roles and said they felt happy with specific comments such as "I love coming to work", "we work well as a team", and "lots of communication."
- A 'corporate colleague of the month' was selected each month.

Public engagement

- There was mixed patient, public and staff engagement.
- There was an active Maternity Service Liaison Committee that provided feedback to the service. We saw minutes of the meeting and noted there was lay and professional representation on the MSLC and that community managers attended meetings. A member of the Patient Experience team also attended MSLC meetings to hear women's views.

- The HoM reported good working relationships with commissioners and met regularly and reported progress through formal stakeholder meetings.
- The homebirth team held 'Meet your midwives' tea parties and events on Saturdays at the hospital and at a local children's centre so women could meet the team and other women having a home birth.
- In order to listen to patient's views to help shape future services and enhance patient experience, we saw the trust was holding a coffee morning to enable members of the public to meet senior midwifery staff to share their stories, discuss any concerns or suggestions for improvement. This was advertised on the trust website.

Staff engagement

- One team told us they had regular staff engagement meetings with external and internal guest speakers to support the team to remain updated with current developments and research.
- Team managers held a community engagement event on 10 July 2015 with good staff attendance. Staff reported the event to be very useful in informing them of local developments. We saw the event evaluation forms, which included details of the event, feedback from staff and attendance figures. There were forty five delegates in attendance, thirty one of whom completed an evaluation form, in which 71% rated the day as 'excellent' and 29% as 'good.'
- Staff told us that they received feedback in various ways including at team meetings, and a quality and risk newsletter called 'Risky Business.' If they submitted a Datix form, staff received personal feedback on the incident reported. Performance issues were taken up with the individual staff member.

Innovation, improvement and sustainability

- Video books were available for women who did not speak or read English which meant women had access to information about the service and their care and treatment.
- BWHFT were awarded a Service Development and Improvement Plan (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service.
- Funding was sought from the Local Education Training Council (LETC) to fund a two year foundation degree to enable the MA's to acquire the necessary competencies to assist the midwife at a birth. BWNFT have also been selected as finalist for the regional small employer apprentice award and an individual MA was selected as a finalist.
- BWNFT were amongst the 20 shortlisted for the NICE service innovation awards and presented a poster and spoke at the NICE National Conference 2015.

Surgery (gynaecology) and Termination of Pregnancy

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

Information about the service

For surgery (gynaecology)

The trust provides gynaecological surgery for women in Birmingham and the surrounding area. Between April 2015 and March 2016 there were 2,664 planned admissions to the service and 1,580 emergency admissions.

As part of the surgery core service we visited all in patient gynaecological services including:

- A pre-operative assessment unit and uro-gynaecology area (ward 2)
- Gynaecology inpatient and day case surgery wards (ward 7 and ward 8)
- The early pregnancy assessment unit (EPAU)
- Operating theatres used by the gynaecology surgery team

End of life care was also reviewed by the inspection team, although the number of people receiving end of life care was very low as those people requiring palliative care were referred to other providers.

Throughout this report, the terms 'surgical services' or 'gynaecology' will be used as collective terms for all the above services, although, if a comment relates to a particular area this will be clearly stated.

Surgical services (gynaecology) were led by a consultant (as the Clinical Director), a Head of Nursing and a General Manager referred to collectively as the divisional leadership team.

During our visit we spoke with six patients and 34 staff including junior doctors, consultants, an anaesthetist, Bands 5, 6 and 7 nurses, operating department practitioner, health care assistants (HCAs), a housekeeping staff, theatre coordinator and ward clerk. We observed care and looked at care and treatment records of 10 patients.

We reviewed the environment and observed infection prevention and control practices. We examined other documentation from stakeholders and performance information for the trust.

For termination of pregnancy services (ToPs)

The trust provides a termination of pregnancy service (ToPs) for women with complex needs and medical conditions that create high risk pregnancy. Referrals were made to Birmingham Women's Hospital from an independent healthcare ToPs provider. GP's did not refer patients directly.

During 2014/15 the trust carried out approximately 600 pregnancy terminations, 322 of which were surgical and 278 were medical procedures. The trust provided its ToPs service through outpatients clinic and inpatient care.

We specifically focussed on the care of one patient, spoke with two patients and visited the outpatient clinic and a ward. We looked at records including 10 sets of patient notes, spoke with 11 staff and observed care.

Surgery (gynaecology) and Termination of Pregnancy

Summary of findings

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

Overall, we rated this service as 'requires improvement;'

Surgical services (gynaecology) and termination of pregnancy services at Birmingham Women's Hospital were caring. Staff were kind and professional in their approach and attentive to patients' needs. Patients felt informed and involved in their care and decisions about their care.

We found some aspects of the services to be safe, effective, responsive and well led but we found some areas in each of these domains required improvement.

We had concerns about the standards of infection prevention and control, the servicing and maintenance of equipment, and the checking and storage of medicines, intravenous fluids and consumables which meant safety required improvement.

Care and treatment was mostly based on evidence based guidance but we found food and fluids were withheld for unnecessarily long periods prior to surgery. Training and professional development of staff were generally good but there had been a lack of training and preparation of staff for some physical and emotional aspects of late terminations of complex pregnancy. The fact that some members of the multi-disciplinary team were not directly employed by the trust reduced flexibility and affected the timely access to some aspects of care.

Services were planned and delivered to meet the needs of the local population and there was evidence of the service working with local commissioners to improve access for patients. However, we noted variations in the flow of patients, which had a potential impact on the efficient use of resources and the ability to respond to the individual needs/preferences of patients.

Leadership within gynaecology was good, however, the priority given to gynaecology within the wider trust was perceived to be low. As a result, there were challenges in moving forward with developments and addressing risks.

The governance framework had been strengthened and progress was being made in addressing the long standing issues. However, the trust had not captured through audit the risk to breach of its condition of registration of ToP services under the Health and Social Care Act or the issues we found in relation to infection prevention and medicines management.

Surgery (gynaecology) and Termination of Pregnancy

Are Surgery (gynaecology) and Termination of Pregnancy services safe?

Requires improvement

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

We found some examples of good practice in relation to the safety of surgical services but we found a number of areas of concern which meant safety overall requires improvement.

We found safety requires improvement because:

- Equipment such as electric beds, weighing scales, and fans had not been serviced and maintained in line with safety requirements and we found consumable items such as swabs and liquids which were past their expiry date in the clinical areas.
- There was no provision for the secure storage of patient records on ward 2 and we found records in unlocked rooms during the inspection.
- We found issues with the storage of medicines and intravenous fluids were not stored safely, as there was open access to the storage areas. We raised this with the management team and action was taken to address this during the inspection.
- Safe infection prevention and control practices were not always followed by staff and although the environment appeared visibly clean, we found numerous pieces of equipment which were labelled as clean but which had not been cleaned as frequently as they should.

However, we also found:

- Incident reporting systems were in place and there was a good culture of reporting incidents and learning from them.
- Procedures were in place to identify and respond to individual risks to patients, such as use of an early warning score to identify early signs of deterioration and use of a checklist at surgery to improve patient safety and reduce errors.

Incidents

For surgery (gynaecology)

- There were no never events in gynaecology between October 2014 and September 2015. There were three serious incidents in that period, two of which related to a delayed diagnosis and the third related to adverse media coverage or public concern. We reviewed the root cause analyses which had been completed in response to the incidents and found an analysis of the contributing factors, had been completed, the root causes had been identified and actions taken to reduce the risk of repetition.
- In gynaecology services, 635 incidents were reported through the trust's electronic system between January 2015 and January 2016 with numbers in the last three quarters being higher than in the first quarter of the year.
- One surgical site infection was reported between February 2015 and February 2016
- Staff were aware of the need to report incidents and told us they were encouraged to do so. This indicated a positive culture of reporting and may have impacted on the higher number of incidents reported in the last three quarters of 2015.
- The gynaecology senior management team told us they reviewed incidents monthly and the clinical improvement group (CIG) discussed any trends or themes identified. Minutes of the CIG confirmed incidents were discussed.
- As a result of a cluster of incidents over six months in relation to bladder and bowel injuries following surgery, these incidents were being examined individually with an immediate review and assessment by the Clinical Director, taking into consideration the patient's individual risk and the severity of the incident.
- Gynaecology morbidity and productivity meetings were held monthly. These were multi-disciplinary meetings to which consultants, junior doctors, matrons, and nurses were invited to attend. Minutes of these meetings were not available for us to review. Staff explained the meetings were useful and well attended.
- Feedback and learning from incidents was communicated in a number of different ways, including through ward meetings, emails and newsletters sent electronically. Staff awareness of these varied considerably and the feedback we received from staff was that electronic information was not consistently accessed.

- Staff were aware of the 'duty of candour' which ensures patients and/or their relatives are informed when they are affected by something which went wrong and are given an apology. The gynaecology clinical governance nurse and consultants took the lead on this.
- A patient told us they had suffered a complication during their operation and this had been explained to them by the consultant following the operation and they had apologised. They said the risk of this complication had been explained to them before the operation and they understood why it had occurred.

For termination of pregnancy services (ToPs)

- Incidents were reported in the ToPs services through the trust's electronic system and staff we spoke with confirmed they reported incidents using this process.
- The gynaecology senior management team told us they reviewed incidents monthly and the clinical improvement group (CIG) discussed any trends or themes identified. Minutes of the CIG confirmed incidents were discussed.
- We looked at five ToPs incidents reported between November 2015 and March 2016 and rated as 'moderate' or 'low' harm. A serious case review (SCR) and the duty of candour consideration was triggered for two of these incidents. The second incident occurred in February 2016 and the SCR was concluded shortly after our visit. The trust had identified root causes and put in place an action plan to address these.
- The SCR for the incident in January 2016, together with further contact and communication with the patient involved resulted in the trust making improvements to the service. We noted this also led to a decision to commission an external review of the termination of pregnancy service by experts from London who deliver a similar specialist service.
- Three incidents related to the foetus showing signs of life. The root cause identified for each was 'lack of guidance for staff faced with this scenario. Education needed for team. Flow chart now developed to be shared with staff. 'We noted during our visits some improvements were put in place to better support staff to manage these circumstances. This resulted in improvement in practice on the occasion of the third incident.
- For example, we saw a flow chart on wards to guide staff in actions of response to late medical termination incidents and foetal signs of life. The trust had requested clarity from the local coroner in response to such incidents. We noted a copy of the coroner's advice accompanied the foetal signs of life flow chart.
- However, although ward nurses told us the flow chart for response was 'up for consultation' and they were encouraged to feedback comments, they said they had not received, by the time of our visit, any additional training to manage this challenging situation.
- The trust also improved support for patients as a result of these incidents. For example, it improved the information registered medical practitioners (RMP) gave to patients during out patient's clinic when they were discussing ToPs treatment options. We heard a patient being told that signs of life were a risk in late gestation terminations and saw the RMP give the patient an information leaflet.

Safety thermometer

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- The NHS Safety Thermometer is an improvement tool to measure patient 'harm' and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections.
- Safety thermometer data was collected by the trust on a monthly basis. Gynaecology reported performance against each of the components of the safety thermometer within their performance metrics on a monthly basis.
- There had been no reports of pressure ulcers between April 2015 and February 2016 and within the same time frame there had been three falls, one in June 2015, November 2015 and February 2016. Reducing catheter associated urinary tract infections was an on-going priority for the service and their metrics indicated they had on average one catheter associated urinary tract infection each month. Audits of VTE assessments indicated these were completed in at least 97% of cases on a monthly basis.
- Safety thermometer data was not displayed on any of the gynaecology wards at the time of the inspection. We

were told it had been displayed previously but the content of the displays were being reviewed by the patient experience team to make them more meaningful to patients.

Cleanliness, infection control and hygiene

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- There were no reports of any MRSA bacteraemia or Clostridium difficile infections during 2015 in gynaecology.
- Screening for MRSA was completed and the criteria for screening was displayed on ward 2 (pre-assessment unit).
- Monthly hand hygiene audits had been completed and indicated compliance of 98% and above. Patients told us staff performed hand hygiene regularly and before each contact. One patient said, "Staff are washing their hands all the time and they use the gel." However, during our visit we observed three occasions when hand hygiene should have been carried out and was not. For example, we saw a member of staff assisting a patient with their wound drain and catheter and then going on to serve patients at lunch without cleansing their hands.
- A patient had been moved to a side room and a sign placed on the door warning staff that the person may have an infectious condition. We observed a member of staff coming out of the side room and although they changed their apron, they did not sanitise their hands and went on to make tea for patients. We raised both issues with the ward sister.
- Not all staff complied with the 'bare below the elbows' policy. We saw two staff members serving food wearing jewellery such as a watch, a large ring (with a stone) and large looped earrings.
- Staff did not always use personal protective clothing and this increased the risk of transmission of infection to other patients. We observed two occasions when staff removed a bed pan from a patient and walked down the ward corridor to dispose of it without wearing an apron or covering the bedpan.
- We asked a senior nurse about the discrepancy between our observations and the hand hygiene audit results. They told us the audits were unannounced and were direct observations, but they felt junior staff might be reluctant to challenge senior staff. However, the staff we observed who were not compliant with the hand hygiene and bare below the elbows policy were not senior staff.
- The environment on the wards and in the operating theatres generally appeared clean and patients told us they felt the environment was clean.
- We found numerous pieces of clinical equipment in the wards which had labels to indicate they were clean. However, the dates on these suggested the equipment had not been cleaned as frequently as it should. For example, some labels indicated clinical trolleys in the treatment rooms had last been cleaned over two weeks prior to our visit. Infusion pumps had not been cleaned for 10 days and were dusty.
- There was no regular routine for cleaning clinical equipment and a member of staff told us the equipment was normally cleaned before use.
- Within the operating theatres, the environment was visibly clean and most of the equipment was labelled to indicate it had been cleaned within the last 24 hours.

Environment and equipment

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Resuscitation equipment was in place on each of the wards and in the operating theatres. These had been checked daily.
- However, there was no defibrillator with the ward resuscitation equipment and we were told the resuscitation team would bring a defibrillator from the operating theatres in the event of a cardiac arrest. This meant a defibrillator would not be immediately available and could result in a delay to treatment. We were told a risk assessment had been undertaken when the decision was made not to provide a defibrillator on the gynaecology wards, but the trust was unable to provide a copy of this during our visit. Following the inspection the trust conducted a risk assessment which resulted in the recommendation that a defibrillator should be placed on each floor of the hospital to ensure swift access by all wards, this has since been actioned.
- The environment appeared well maintained and uncluttered. However, we found a curtained off area in Ward 8 which was used for storing equipment including intravenous pumps, the resuscitation equipment, oxygen and Entonox cylinders, and intravenous fluids.

This area was opposite some side rooms and was unsuitable for storing these items which were unsecured. We raised this with the management team and steps were taken to remove the items and store them securely during the inspection

- Servicing of equipment such as beds and weighing scales were overdue. On ward 7 we found six out of twelve beds we checked were past their servicing date and there was no servicing or calibration date on scales in the pre-operative assessment area. Electrical safety checking of equipment had not been carried out regularly. For example, we found the resuscitation equipment on ward 8 which had an electricity safety check due in March 2015, 10 fans in a store room on ward 7 in which the tests were out of date as per the labels on the equipment, along with a television on ward 8.
- We also found sterile disposable items such as syringes, swabs and catheters which were past their use by date in the ward areas which meant their sterility may have been compromised.

Medicines

For surgery (gynaecology)

- Medicines were generally stored in locked trolleys and cupboards within locked rooms as required. However, we found the keys to a medicines cupboard in the lock of a drug cupboard on ward 2 and we noted the medicines trolley was not secured to the wall on ward 7
- We found several medicines in a medicines cupboard on ward 2 had past their expiry date and should have been returned to pharmacy.
- We found loose strips of medicines not stored in their original container were available in the medicine trolley on wards 7 and 8. A medicine dated 23 July 2014 and labelled for a patient no longer on ward 8 had not been removed for destruction. There was an increased potential for a medicine error.
- Intravenous fluids were not stored securely on wards 7 and 8. This meant the fluids were potentially accessible to unauthorised persons and could be tampered with. We raised this with the management team and steps were taken to move the fluids to a secure area and we were told the stock levels would be reviewed as it was unnecessary to maintain such high stock levels.
- A Clinical Pharmacist visited the ward five days a week for ward 8. They were involved in discussions with doctors and nurses about patients' individual medicine requirements and helped identify medicine issues which could be dealt with immediately. A nurse told us there was a very good relationship with the pharmacy team with access to a pharmacist out of hours if needed.
- Patients who had been assessed as able to look after their own medicines were able to do so. We were shown patients' bedside lockers to store medicines. The key was held by the patient which allowed patient choice and independence in looking after their medicines.
- Medicines administration records we reviewed for gynaecology were completed correctly, were legible, signed consistently and included patient allergies.
- Staff were aware of the trust policy on administration of controlled drugs and the Nursing and Midwifery Council Standards for Medicines Management.
- Syringe drivers for people needing continuous pain relief were available. Staff were aware of how to use these effectively.
- Medicine incidents were reported with lessons learned and shared at ward meetings. We were told about a near miss medicine incident on the ward which identified a potential problem. Following this incident positive action was taken to prevent it happening again.

For termination of pregnancy services (ToPs)

- In relation to termination of pregnancy (ToPs) we looked at 10 sets of patient records and observed a ToPs 'outpatients' clinic.
- Medication for medical termination of pregnancy was prescribed and administered by the appropriate clinical staff as required by The Abortion Regulations 1991.
- Records were made of administration of those and other ToPs related medication and we saw these in patient's files.

Records

For surgery (gynaecology)

- The areas we inspected used a combination of paper records and a computerised nursing care planning system which was password protected.
- Medical records were stored in notes trolleys and storage units on the ward areas but although they were

kept away from the public areas they were not secured. We noted there were some occasions when the area was unstaffed and therefore could have been accessed by unauthorised persons.

- Care records were found in unlocked rooms on ward 2 and in one case the door was left open. When we talked with staff working in the area they told us they had raised the issue of security with a senior nurse as they had no lockable space for care records but no action had been taken.
- Medical records were separate to nursing records and contained a clear plan for the patient's care and a review of progress on a daily or twice daily basis. We reviewed 10 sets of medical records for gynaecology and these were well organised, legible, dated, signed and generally complete.
- Standardised nursing care plans were in place on the electronic system which gave an outline of people's care and treatment needs. However, they were not detailed and did not always identify the specific interventions and frequency of interventions required. We talked with staff about this and they accepted it would be difficult to provide care based on the care plans alone, but the details were provided in clinical guidelines, and handover was comprehensive.
- Pre-operative assessments were completed in a specialist area before admission. The assessment results were placed in the medical record and transferred to the ward with the records prior to admission. A pre-operative checklist was completed prior to transfer to theatre to ensure all the necessary checks had been completed.
- Entries in medical records were dated, timed and signed with the person's name and designation printed underneath. Entries on the computerised care planning system was dated and timed and there was a record of the person who had made the entry.
- The trust cared for very few patients at the end of their life and therefore there had only been one occasion within the last year where a patient had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order in place. An audit carried out by the resuscitation service indicated that it had been completed appropriately.

For termination of pregnancy services (ToPs)

- ToPs used a combination of paper records and a computerised nursing care planning system which was password protected. We looked at 10 sets of paper files for patients who underwent a termination of pregnancy. These were well organised, legible, dated, signed and generally complete.
- Risk assessments had been designed into the patient pathway care document completed at the outpatients clinic and we noted a system of 'risk stickers' were in place and used on records. This alerted all staff subsequently using the records to typical risks for that patient.
- The pre-operative assessment records and checks made by medical staff were on file for patients that underwent a surgical termination of pregnancy.
- Each patient file included the certification form HSA1 required by the Abortion Regulations 1991. Each was signed appropriately by two different named registered medical practitioners (RMP). This certified that each had agreed an opinion in good faith on a single 'lawful ground' under the Abortion Act 1967.
- We noted the RMP had dated each HSA1 certificate and clearly identified the agreed 'ground' for the termination.
- We noted in some files the independent healthcare provider who referred the patient had sent a HSA1 certificate already signed by one RMP. In these cases the trust completed a fresh HSA1 with two RMP's certificating after they had checked the gestation period of the foetus. This ensured the RMP's practised within the law and the trust policy for ToP.
- We observed an outpatient's clinic for ToPs. We noted there was a system in place for two RMP's to separately see and assess the patient before certifying an opinion on the HSA1 and we saw this in action. This ensured the RMP's practised within the law.
- However, out of 10 patients files we looked at we found five indicating the patient had not been 'seen/treated' by either of the two RMPs who signed the certificate.
- Evidence in the rest of the file indicated otherwise. This was because a part of this legal form had not been properly completed. We raised this matter with the trust at the end of our visit and it arranged an audit of all ToPs patient files, At the time of publishing this report, these results were not available.
- Clinical staff told us the legal HSA4 form to notify the department of health of a termination of pregnancy, was completed after the procedure and sent off as it

should be. These were sent electronically to avoid risk of loss. We noted a copy of this form including the names of both RMP's who certified the HSA1 form in progress in a patient's notes on the ward.

Safeguarding

For surgery (gynaecology)

- The proportion of staff having undertaken safeguarding training was 99.2% in February 2016.
- Safeguarding training included information about female genital mutilation to raise staff awareness of the issue.
- Staff were aware of the process for reporting safeguarding concerns and were able to identify the name of the safeguarding lead. A member of staff had raised a safeguarding concern and told us they had felt supported by the safeguarding lead.

For termination of pregnancy services (ToPs)

- We noted the trust included in its operational policy for women seeking abortion care consideration of needs of 'vulnerable' women during assessment. Also included were clear directions for clinicians about responding to children under 16 seeking abortion care, children 13 and under and reference to information on the Gillick competence.
- The patient pathway care document, designed by the complex care abortion service, included an explicit safeguarding question 'do you feel safe where you are currently living?' The RMP was to ask the patient this question to open up a discussion about safety and there was a free text box to complete the answer.
- Each of the 10 patient records we looked at had information completed in this box. We heard an RMP address this in a consultation and heard exploration of the issues it raised including about existing children in the family. This showed a safeguarding procedure was embedded in ToPs practice.
- However, we found during a ToPs clinic the RMP accepted on face value some information that could have been referred to the trust's children safeguarding lead for further enquiry. They did not record this information.
- Other RMP's we checked this with confirmed although they asked, they did not necessarily pursue the situation of other children in the patient's life. We raised this with the safeguarding children's lead for the trust who confirmed achieving assurance about other children was in keeping with trust policy. They undertook to follow this up.

Mandatory training

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Information provided by the trust for gynaecology showed that 93% of staff were up to date with the required mandatory training in March 2016. At least 90% of staff had completed each mandatory training course except fire training (82%) and moving and handling training (82%), against a target of 85%.
- Staff told us there was an opportunity to complete additional training and this was encouraged.
- As patients at the end of their life were cared for very infrequently at the trust, end of life care training was not mandatory. Data the trust provided indicated that all nurses at band 7 and above had completed end of life training previously and a small proportion of nurses below band 7 had undertaken training. However, there had been no attendance at end of life training within the twelve months prior to the inspection, and not classed as mandatory.

Assessing and responding to patient risk

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Patients requiring elective surgery were assessed in the pre-operative assessment area by a team of registered nurses working closely with the anaesthetists as necessary.
- Patients who were at high risk due to co-morbidities or other factors which increased their risk of complications following surgery were identified by medical staff in the outpatients department, who liaised with the anaesthetists to ensure the anaesthetist was able to undertake a full assessment during the pre-operative assessment process. These patients were cared for in the Gynaecology Extended Recovery Unit (GERU) for 24 hours after surgery. This unit opened only when necessary and had a maximum of two fully monitored beds. Two staff members who had undertaken additional training were allocated to the unit.

Surgery (gynaecology) and Termination of Pregnancy

- Risk assessments were completed for each patient on their admission, to assess their risk of malnutrition, developing pressure ulcers and venous thromboembolism. These had been reviewed appropriately.
- Termination of pregnancy patients were nursed on gynaecology wards. Compliance for life support (BLS) training was 100% for staff on those wards.
- An Early Warning Score (MEWS) was in use to aid identification of deterioration in a patient's condition. The score had been completed with each set of vital signs observations. The observation charts did not indicate the frequency of observations required, however, we saw the frequency of observations were consistent with the frequency normally in place following surgery.
- The observation chart contained guidance on the MEWS scoring system on the reverse and when escalation was needed. We saw that when the score indicated escalation was needed, this had been undertaken.
- Staff we talked with understood the requirements for escalation of clinical concerns. They said sometimes if, when escalating to junior doctors, they were unable to attend or did not answer, in these cases they would escalate to the registrar or consultant. Junior nursing staff said they would escalate to the Nurse In Charge initially and they would escalate further.
- In the operating theatre, the world health organisation (WHO) safer surgery checklist was completed and the checklist stored in the patient's care record. We observed this in use and saw completed forms in the care records we reviewed. We noted each of the seven files we looked at for patients undergoing surgical termination of pregnancy recorded use of this checklist.
- Quarterly audits of compliance with the WHO checklist indicated the checklist had been used in all cases reviewed and it had been fully completed in at least 97% of cases in 11 of the 12 months of 2015. There was no quarterly data available for January 2015 to March 2016.

Nursing staffing

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Nurse staffing levels had been reviewed six monthly using a recognised tool (adapted Shelford Group, Safer Nursing Care tool) and staffing levels were in line with those recommended in the tool. Staffing levels were monitored daily and incidents of sub-optimal staffing levels reported. There had been three such incidents between April 2015 and April 2016.
- Staff told us they felt staffing levels enabled them to provide a good level of care. Staffing was flexed across Wards 7 and 8 in order to respond to fluctuations in demand.
- Patients we talked with told us they did not feel there was any shortage of staff and many patients we talked with said they had not needed to use their call bells as staff were always accessible and checked on them regularly.
- An e-rostering system had been introduced at the trust and staff in gynaecology identified issues with the rosters produced. For example, skill mix was not sufficiently taken into account and a person could be rostered on long shifts, short shifts and night shifts in the same week.
- Senior staff identified the rules within the e-rostering system had needed to be adjusted and although it had improved, further work was needed to refine the system. Nurses told us the rostering had not improved.
- There was no identified palliative care team at the trust, however, the Oncology Nurse Specialist was involved in the care of patients at the end of their life and the trust had good links with the hospice for advice when required.

Surgical staffing

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- The early pregnancy assessment unit (EPAU) had rostered junior doctor cover weekdays from 8.30am and on-call cover after 6pm.
- From 1pm to 9pm the junior doctor was shared with midwifery and the out of hours on call team was also shared with midwifery.
- Junior doctors told us there were no issues with the rotas and they said they were able to raise concerns with the on call consultant who answered immediately.
- A consultant was available for EPAU and gynaecology surgery weekdays and there was a resident on call from 9am to 1pm at weekends. Outside normal working hours, a consultant provided on call cover.
- Nurses on the gynaecology wards told us there were difficulties in obtaining reviews of patients after 5pm as

the junior doctors were busy in maternity. One nurse said, "It is particularly a problem when women come from A&E as they may have been in A&E for hours." An experienced nurse told us, "Obstetrics gets priority, even when the issues here are just as urgent." "During the night you have to phone the registrar just to get them over here."

- Patients told us they saw the doctors every day. One person said, "The junior doctors are very good."
- The trust did not employ their own anaesthetists; they were provided by the University Hospital, Birmingham. There was a Lead Anaesthetist for the trust but the anaesthetists allocated for gynaecology were general anaesthetists and the same anaesthetists were not allocated to the gynaecology services regularly. However, the staff told us the anaesthetists liaised closely with the pre-operative assessment unit and we observed a routine visit by an anaesthetist to the pre-assessment unit during our inspection. Anaesthetic cover out of hours was shared with obstetric services.

Major incident awareness and training

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Staff had not received any training in major incidents and some were unaware of their responsibilities.
- The hospital would not be a designated receiving hospital in a major incident/disaster.
- We reviewed a business continuity plan for the mortuary which outlined procedures in the case of a disruption of activity due to unforeseen circumstances and found this to be fit for purpose.

Are Surgery (gynaecology) and Termination of Pregnancy services effective?

(for example, treatment is effective)

Requires improvement

We found effective requires improvement because:

- Patients reported unnecessarily lengthy periods when they were unable to eat and drink prior to their operation and we found there were variations in the instructions about this for patients, depending on the anaesthetist involved. The trust had been unable to reach a consensus in order to achieve a consistent approach and reduce the amount of time patients were unable to eat and drink to a minimum.
- There was good multi-disciplinary team working, however due to the size of the service, some members of the multi-disciplinary team were not directly employed by the trust and this sometimes created problems in accessing other professional input in a timely manner.
- Staff were not sufficiently trained and for the changes to the abortion service provided by the trust.

However, we also found:

- Evidence based guidance was available within surgery (gynaecology and termination of pregnancy) and care was provided in line with the guidance.
- A range of patient outcomes were measured and indicated outcomes were comparable to other similar services.
- Staff generally had good access to training and professional development.
- The average length of stay for elective gynaecology was in line with the England average (August 2014 – July 2015).
- Consent for surgery had been signed by patients and completed appropriately in the care records we reviewed.

Evidence-based care and treatment

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Policies and procedures had been developed in line with current best practice guidance including guidance from the National Institute of Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists.
- We saw examples of preoperative and perioperative guidelines based on national guidance.
- Audits of compliance with NICE guidance had been completed and a gap analysis undertaken with a timescale for review.
- NICE guidance on recognising and responding to deterioration in acutely ill patients was being followed and a recognised early warning score was in place.

Surgery (gynaecology) and Termination of Pregnancy

- The early pregnancy assessment service was expanded to seven days a week in response to NICE guidance, through negotiations with the commissioners.
- A sepsis pathway had recently been introduced and an audit of sepsis was carried out on a quarterly basis.
- A joint care pathway had been developed with University Hospitals, Birmingham for the shared care of patients requiring uterine artery embolisation (a procedure to block the blood supply to fibroids in the uterus).
- Cancer network guidelines and pathways were followed for patients with cancer and patients were referred to the appropriate provider.
- An audit of adherence to department guidelines in the gynaecology extended recovery unit had been completed by reviewing care records.
- Examples of local audits which were being undertaken included: follow up of patients in the menopause clinic, urinary tract infection rates following urodynamic investigations, and removal of urinary catheters following surgery.
- There did not appear to be any mechanisms for sharing the results of audits with midwives or other specialties.
- An adult 'do not attempt resuscitation' (DNAR) procedure had been developed in line with national guidance for 'do not attempt cardio-pulmonary resuscitation' (DNACPR) which complied with the guidance issued by the Resuscitation Council (UK).

For termination of pregnancy services (ToPs)

- Divisional leaders told us the trust was not commissioned to provide counselling or family planning. It was intending to be able to provide these services as part of the complex abortion care pathway in the future. Counselling was on offer by the referring independent health care provider. Use of contraception was promoted at an outpatient clinic and we saw patients were prescribed or given some contraception of their choice before they left.
- For termination of pregnancy services (ToPs) we observed and noted from ten sets of patient records, patients were given good and clear information about the termination options available to them provided by the trust. This is in line with the department of health and RCOG guidelines.
- However, nurses on wards caring for complex abortion services patients confirmed they had no agreed differential care pathways. They needed guidance in best practice and sensitive management care of a foetus where the patients' emotional and psychological needs may significantly differ due to the reason for the decision to terminate the pregnancy.
- We noted a pathway was available and under consultation at the time of our visit for staff to follow where a late gestation medical termination of pregnancy resulted in the birth of a foetus that could be showing 'signs of life.'
- There was a patient information leaflet for surgical and medical termination of pregnancy. We saw patients given these by the registered medical practitioner (RMP) at the outpatients clinic which was in line with the 2014 Department of Health guidance in relation to requirements of the Abortion Act.
- However, we noted the information on medical terminations of pregnancy did not include the risk of a late gestation foetus showing 'signs of life' and the potential requirement to register this with the coroner. We heard the MRP in the outpatients' clinic give this information verbally to patients.
- The root cause analysis of an incident that took place in February 2016 identified a patient had not been referred to the correct clinical care pathway from the fetal medicine service. This had contributed to the poor outcomes experienced by the patient.

Pain relief

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Procedures were in place to ensure patients received pain relief when it was required.
- Patients were asked if they had any pain during two hourly comfort rounds and patients told us staff responded quickly with pain relief when required.
- Patient controlled analgesia was in place for some patients post-operatively and patients told us staff had explained how the pump worked and that they could not give themselves more than the doctor had prescribed, due to the safety mechanisms built into the pump. They said they had been told to let staff know if they needed any additional pain relief.
- Patients told us and we saw in the records, staff checked whether patients had any pain every time they did their

observations. One patient said, "My pain has been completely controlled." Another patient said they had had some slight pain but the medication had been effective.
- There was no dedicated pain management team which meant individual anaesthetists and consultants were consulted regarding pain management for patients.

Nutrition and hydration

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Patients were assessed on admission for their risk of malnutrition using a recognised assessment tool.
- Staff communicated at handover if a patient was to have nothing to eat or drink before surgery.
- Patients we talked with told us they had been told to have nothing to eat from 12 midnight on the day of their admission for their operation and to have no fluids from midnight if they were scheduled for surgery in the morning or from 6am if their surgery was scheduled for the afternoon. One patient told us their surgery had been later than expected due to the need for an emergency patient to be added to the list and they had not gone to theatre until after lunch, having been without food from midnight.
- This meant patients sometimes were without food and fluids for 12 hours preoperatively which could have impacted on their recovery. Time without fluids was at least five hours which is much longer than the two hours which the Royal College of Anaesthetists recommends.
- The divisional leadership team told us the theatre management group which included anaesthetists, had discussed preoperative fasting. However, they had been unable to achieve an agreement amongst the anaesthetists as to preoperative fasting times. The anaesthetists were not employed by the trust and there were no regular anaesthetists for some lists. Local leaders told us audits completed on preoperative fasting had shown some clinical variation between the lists.
- A theatre meeting was held every day and a message was sent to the ward as to which patients could have their drinks extended. If a person who was having major surgery was delayed, they would be given intravenous fluids.
- We saw jugs of water were provided at each patient's bedside and there were regular hot drinks rounds. Patients told us they were offered plenty of drinks and if a nurse saw their jug was empty they would ensure it was re-filled.
- Fluid intake and output charts were completed post operatively. They had been completed consistently and the fluid intake and output had been totalled every 24 hours. We did not see any evidence of fluid targets being set for people.
- Ward 8 had a dining room which enabled patients to eat their meals away from their bed area if they wished. A patient commented positively about this to us.
- Patients told us there was a choice of food and menus were displayed in the ward areas. One patient said, "The food is plain. There is a reasonable choice. It's ok but not great."
- We observed a lunchtime meal being served, some patients eat in the dining room and there was a choice of two meals. A poster in the dining room advised patients of the availability of Halal meals. This was printed in English and two other languages.

Patient outcomes

For surgery (gynaecology)

- The average length of stay for elective gynaecology was in line with the England average (August 2014 – July 2015). The average length of stay for non-elective gynaecology was below average at 1.1 days compared to an England average of 1.9 days in the same period. It is difficult to draw conclusions from this due to the specialist nature of the trust; however it meant patients were able to leave hospital as soon as possible without their discharge being delayed.
- National data indicated the relative risk of being re-admitted to hospital was higher than the England average for elective gynaecology and lower than the England average for non-elective gynaecology (August 2014-July 2015).
- The divisional leadership team were unaware of this data but identified factors which may have influenced this such as planned re-admissions for interventions following discharge and coding issues. Another example was patients on the hyperemesis (severe, persistent vomiting occurring during pregnancy) pathway had frequent attendances and might be re-admitted.

Surgery (gynaecology) and Termination of Pregnancy

- The trust monitored their re-admissions on a monthly basis and had set their own threshold of no more than 6% of patients to be re-admitted. Their data indicated they had been below this target every month from January to December 2015. When they exceeded the threshold in January 2016 they carried out a case review but did not identify any trends or themes.
- In the six months between October 2015 and March 2016, less than 1.4% of patients had their elective surgery cancelled on the day of surgery and all of these had their operation carried out within 16 days of the cancellation date.
- The trust did not have any published data from participation in the national cancer audit as their numbers were too small. However, it did participate and submitted data. We were told it conducted peer reviews with a similar service although we requested this information but we were not provided with any results from this.
- There was one surgical site infection between January 2015 and January 2016. Surgical site infections are reported nationally for infections following abdominal hysterectomy when patients are re-admitted to hospital.
- The trust did not participate in the national care of the dying audit for hospitals (NCDAH) because of the low numbers of patients who had died at the hospital.

For termination of pregnancy services (ToPs)

- The divisional leadership team responsible for the ToP service told us they bench mark with the late surgical terminations specialist NHS service out of region to learn from their referrals to this service.
- We noted from each of the 10 patients' care records we looked at who underwent ToP and our observations in the outpatient's clinic that patients were given advice on contraception. Prescriptions were written or alternative birth control methods agreed and arranged before patients left the clinic. In keeping with recognised good practice, the trust offered the means of reducing the need for further terminations to women.
- The trust had provided the complex abortion care service for ToP as a cohesive pathway for only 15 months at the time of our visit. This meant few clinical and procedural audits had been undertaken.
- The trust had A commissioning for quality and innovation (CQUIN) for 2015/16 aiming 'to record the time between referral to patient attendance at BWH for complex abortions and improving the process where necessary.'
- Data collected for Quarter 1/Quarter 2 showed gestation age at time of referral and gestation age at time of referral to the trust for complex abortion care. This showed between January and September 2015, 93% of women who were referred and had an abortion were referred for medical complexity. Divisional leaders told us they were satisfied the abortion care service was being used appropriately.
- The average gestation in weeks at decision to proceed (BWH) was eight weeks. The average time between referral to the trust and appointment across this time period was 4.5 days
- The trust reported it found the gestational age on referral was unknown data and difficult to collect. Internal referrals from maternity were easily tracked and patients were seen on the day or within three days of referrals.
- From this audit activity the trust found some instances in this time period at which the gestational age noted on the referral (which suggested that these women were telephone triaged and seen in a stand-alone clinic) differed by 1.3 weeks. In one instance, this changed the procedure from medical to surgical termination.
- The trust reported its intention to enable reconciliation with the recorded scanned gestational age at BWH at point of referral. To do this the complex abortion care service was working with the independent health care providers to ascertain from each of the referrals received and treated at BWH, when the first contact with those providers was made.
- The CQUIN data collected for Quarter 3 showed from the 90 referrals into the service only four patients were identified as 'other' on the referral form. All other referrals had clear clinical indications identified. This demonstrated to the trust that 95.5% of patients referred into the service received abortion care treatment due to medical complexity.
- We saw minutes of a meeting held by the trust and divisional leaders during 2015 to bring trust policy and procedures in relation to foetal remains and the products of conception into line with the Human Tissue Authority (HTA) guidelines. An action plan was put in place and was monitored through these meetings.

Surgery (gynaecology) and Termination of Pregnancy

Competent staff

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Staff completed an induction on commencing work in gynaecology and staff told us they felt the induction was thorough. A nurse described their induction period, during which they completed their mandatory training and had a supernumerary period of two weeks. Another staff member described spending time in other departments during their induction period to gain a broader understanding of the service.
- Nursing staff reported they had access to training and development opportunities. The trust recognised career progression opportunities were limited so accessibility to courses such as ultrasound scanning enabled them to develop within their roles.
- Junior medical staff told us they had completed an induction which included training topics specific to gynaecology, in addition to general mandatory training.
- A junior doctor told us the training was very good. They said there was lots of opportunity to work with direct or indirect supervision. They told us they had direct access to the consultants for advice, and the consultants were happy to talk with the junior staff. Other junior doctors we talked with also felt well supported and told us they had access to training.
- We talked with two student midwives and a trainee operating department technician. They all told us they had been allocated a mentor and said staff were very supportive.
- Data supplied by the trust indicated in December 2015, 86% of staff in the gynaecology and fertility directorate had received an appraisal within the previous 12 months, against a target of 85%. Staff told us they had a discussion about their learning and development needs at their annual appraisal and from this additional training was identified.
- Patients told us they had trust and confidence in the staff caring for them. One patient said: "I feel really relaxed, the staff are very capable."
- Staff had not attended any recent training on end of life care (EOLC). The trust was not a cancer centre and patients with cancer, other than a very early stage cancer, were transferred to other hospital and hospice services. The oncology clinical nurse specialist told us they were present to provide support at any appointments when a cancer diagnosis was being given and they felt competent in this role.
- Nurses in the preoperative assessment unit had completed a recognised course to provide them with the additional skills and knowledge required for the role. We talked with staff in other areas of gynaecology who had accessed training to enable them to expand their roles.

For termination of pregnancy services (ToPs)

- Divisional leaders told us the trust did not use the Royal College of Nursing ToP framework. They sourced competencies from Sheffield Group of Hospitals. Staff were in the process of developing this in line with local requirements, with support from one of the abortion care service consultants and the Head of Nursing.
- The dedicated staff capacity had been improved by January 2015 to three consultants and one band 6 specialist nurse (three days a week). One consultant was a specialist in sexual health. The team also included two medical trainees in community sexual health.
- There was a core group of nurses who expressed an interest in the development of the complex abortion care service. A system of champions and linked and named nurses was being developed to further support ward staff.
- Divisional leaders told us inpatient and outpatient staff were supported by the complex abortion care service. We saw the specialist nurse working in the outpatients clinic.
- However, several nurses on wards expressed concerns to us as they had not received training that would equip them to deal with the physical and emotional aspects of advanced gestation abortions.
- They said, in addition to two incidents (trust data showed five for Quarter four in 2015/16]) they reported on the trust's incident reporting system, there were other occasions when the condition of the foetus had given them cause for concern and the action they should have taken was unclear. However, we noted the root cause analysis (RCA) for a third incident reported the impact as 'low' because all staff had responded appropriately on that occasion due to learning embedded from the first incident.
- Ward nurses told us the complex abortion care service staff did not have a presence on the ward and despite

the reported incidents there was still no written guidance for staff and no training plan. However, there was some guidance about foetal signs of life being trialled on wards at the time of our visit.

- We carried out an unannounced visit to the gynaecology ward that specialised in caring for patients undergoing late gestation termination of pregnancy. This was to follow the care pathways of patient's we knew were to be admitted that day for late gestation medical termination of pregnancy.
- We found an experienced band Six nurse in charge supported by a staff nurse. The nurse in charge confirmed the complex abortion care service team had contacted the ward to check the staffing rosters in advance of that day to make sure there were experienced staff on duty. Also staff on duty that did not hold a conscientious objection and who would not therefore be expected to participate in providing the treatment.
- Divisional leaders told us this process was also followed for theatre staff where a surgical termination was listed.
- There was a 24/7 advice line in place on wards for nurses available one to one or group counselling sessions for staff following any ToPs incident that they found upsetting or challenging.

Multidisciplinary working

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Medical, nursing and ancillary staff all described good multi-disciplinary working and we saw this in practice. One of the clinical staff said they felt it was a supportive environment and there was a healthy challenge between nurses and doctors.
- Staff in the preoperative assessment area described an excellent relationship with the anaesthetists and they felt they could obtain assistance when required.
- There was a service level agreement with Birmingham Community NHS trust services for access to a dietician. However, an increased level of support was felt to be required. We were told the trust was in the process of identifying the amount of support needed particularly in view of the increase in numbers of bariatric patients and those with hyperemesis.
- An example of different departments and professionals working together effectively was given in relation to planning the admission of a patient with advanced dementia for surgery. All team members were aware of the person with overall responsibility for each person's care.
- The clinical nurse specialist for oncology was the primary contact for cancer in the trust and was the main link with the cancer centre. Information from the cancer network was cascaded through the clinical nurse specialist and they linked with other clinical nurse specialists across the network.
- Guidance was provided on the transfer of patients to other services and providers including the referral to other services when a malignancy was diagnosed.

For termination of pregnancy services (ToPs)

- For ToPs we noted from records, a good example of internal MDT working on developing guidance. Reviewing and updating guidance on the disposal of pregnancy remains following pregnancy loss or termination involved a number of disciplines within the trust supporting the complex abortion care team during 2015.
- However on a daily practice basis, the root cause analysis of an incident that led to a serious case review underway at the time of our inspection indicated differently. It identified teamwork between the abortion care service, ward team and bereavement team and wider medical team needed to be strengthened.

Seven-day services

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Gynaecology planned surgery took place from Monday to Friday and theatre slots were allocated for emergencies during these lists. Urgent unplanned surgery was also undertaken after 5.30pm.
- The consultant on call rota meant there was a consultant on call at all times and on site seven days a week.
- In addition to sonographers, the consultants and senior registrars were able to carry out scanning providing emergency cover seven days a week. Non emergencies could also be referred to University Hospital, Birmingham which was situated next to the Birmingham Women's Hospital.

- There was an onsite commercial pharmacy which provided both inpatient and outpatient pharmacy services. They were open from Monday to Friday and Saturday mornings. Out of hours services were provided by a Service Level Agreement with another provider.
- The chaplaincy service was available for spiritual support out of hours via the trust switchboard.

Access to information

For surgery (gynaecology)

- Staff told us medical records were received in a timely manner and if they had to be requested, they were swiftly obtained from the medical records department. We saw this was the case in respect of a set of records we requested while we were on the ward.
- An electronic care planning system was in place in gynaecology. We found the system slow to respond at times and difficult to navigate. Staff we talked with told us they experienced difficulties with the system due to the speed of response, problems with accessing the system and the system crashing.
- For example, a member of staff said they had spent 30 minutes on a morning during the inspection, trying to log onto the laptop in order to complete the admission of a patient. As a result, they had not been able to admit the patient at their bed side which was the aim of using portable IT appliances.
- Protocols and guidelines were available electronically and staff found them easy to access and generally up to date.
- General practitioners (GP) had direct access by telephone to the consultant on call for advice.

For termination of pregnancy services (ToPs)

- We saw in patients' files information and assessments sent from referring independent health care providers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

For surgery (gynaecology

- Consent for surgery had been signed by patients and completed appropriately in the care records we reviewed. Records indicated that discussion had taken place with the patient and they had understood the information given.
- Audits of consent had not been completed in gynaecology so the trust was not able to provide evidence of the level of compliance with best practice in relation to consent.
- A junior doctor told us they had not received any specific training for consent but they were aware of the requirements in relation to patients aged 16 years or younger.
- A patient told us they felt in control of decisions about their care and treatment. They told us when they had first attended the hospital, they had been surprised about the operation they were told was required. They said they had been able to go away and think about it and could contact the hospital when they had made the decision as to whether they wanted to go ahead. They told us they had been given a lot of written information, so when they gave their consent they felt fully informed.
- Most staff had a basic awareness of the Mental Capacity Act. They told us when a person was not able to make decisions about their care or treatment themselves, and a mental capacity assessment was required, they would obtain support from the safeguarding lead to undertake this.
- The trust had recently produced fundamental information on the Mental Capacity Act on small cards for staff to keep and refer to. Staff felt this was a positive and useful initiative.
- We reviewed the records of a patient who had been admitted to the gynaecology ward at the time of our visit. We found a mental capacity assessment had been completed, however, the specific decision was not clearly documented, there was no information about other options considered and the reason why surgery was necessary was not included in the best interest decision making documentation.
- Staff had identified the need for a deprivation of liberty (DoLs) authorisation for the patient and we saw the required application had been submitted.
- The trust was supported by the resuscitation team at University Hospital, Birmingham and a copy of any DNACPR orders for patients at Birmingham Women's Hospital were sent to the team.
- According to trust records, only one patient had a DNACPR order in place in the twelve months prior to our visit. An audit of this completed by the resuscitation

team, had indicated it was completed in line with guidance. There were no inpatients with a DNACPR order in place at the time of our visit so we were unable to review this.
- The Clinical Nurse Specialist for Oncology was involved in the care of patients with DNACPR orders and they ensured information was communicated with all of those involved in the patient's care.

For termination of pregnancy services (ToPs)

- Consent was obtained and recorded on all of the ten patient files we looked at. This included consent to the termination of pregnancy by the method agreed and consent to disposal of the pregnancy remains.
- One patient whose file we looked at had requested a surgical termination of pregnancy was noted on record as 'severely learning disabled' and was accompanied by a parent.
- The assessing medical practitioner had recorded the patient as 'Fraser Competent' but did not note how this decision was arrived at. Fraser Competent is a term used to describe a child under 16 who is considered to have sufficient maturity and intelligence to understand the nature and implications of the proposed treatment (for sexually transmitted infections and termination of pregnancy) and contraceptive advice without parental knowledge or consent. We raised this with the trust after our visit and it undertook to investigate it.
- The trust acknowledged this was not an appropriate approach to supporting consent for treatment from women with learning disabilities. It told us it had provided extra training for clinicians since our inspection visit and reviewedsome of the language clinicians used in their professional notes. However we were not completely satisfied that plans were being developed to holistically address the issue of pathways for patients with learning disabilities across the service'.
- We saw from observation and patients notes that the RMP's who saw the patients in clinic gave them good information about termination of pregnancy, explained and discussed the different methods available and gave them written information to take away. We heard the doctors clearly telling patients they could change their mind even after they had signed their consent forms.
- The trust undertook a Gap Analysis and produced an Action Plan dated June 2016 against the Human Tissue Authority: Guidance on the disposal of pregnancy remains following pregnancy loss or termination March 2015.
- This raised a number of actions required to improve the information and support given to patients over decisions and consent that were only partially met at that time. Actions achieved at the time of our visit included revising the consent forms. However, we noted these forms were likely to remain difficult for some women to understand because of their complex language. There was no easy read or pictorial version to support a patient to verbally explore meaning.

Are Surgery (gynaecology) and Termination of Pregnancy services caring?

Good

We found caring was good because:

- Patients praised the staff for their caring and professional approach. They told us staff were attentive to their needs and provided excellent emotional support. This corresponded with our observations during the inspection.
- Patients' privacy was respected and facilities were available to enable private discussions to take place when this was required.
- Patients were provided with the information they required to enable them to be fully involved in decisions about their care and treatment.

Compassionate care

For surgery (gynaecology)

- Patients spoke highly of the staff caring for them. Comments such as, "Staff are brilliant. They helped me when I needed it,"; "The nurses are kind to all of us,"; "Staff are pleasant and friendly," were received from patients we talked with.
- Patients also talked positively about the anaesthetists, surgical doctors and theatre staff. One person said, "The porters were friendly and joked with me when they took

me to theatre. It made me feel less anxious." They also said the fact they didn't have to wait when they arrived in theatre was helpful as waiting would have increased their anxiety.
- Patients told us the nurses introduced themselves when they arrived on shift and we observed staff greeting patients by name when they met them in the corridor.
- Patients told us and we observed, that staff were attentive to their needs and checked their well-being. A patient told us they appreciated being asked if they would like a shower as they would not have asked. They said they had come in without toiletries as they had not been expecting to be admitted and staff checked whether they had supplies and provided these for them. They said, "Staff walked with me to the shower and showed me the pull cords to use if I needed help."
- We saw a display on the information boards on the wards reminding staff to check whether people required assistance, stating "No pass zone" – "Don't pass a visitor or patient in need."
- Staff told us patients were offered a chaperone and staff were available to act as chaperones. Relatives were not asked to act as chaperones.
- We saw there had been some complaints about staff attitude, mainly about administration and clerical staff. Divisional leaders told us they were undertaking an initiative to increase awareness amongst staff of their impact on patients' experience by facilitating reflection on the patient journey and looking at the journey through the eyes of the patient.
- The NHS friends and family test (FFT) score for gynaecology in December 2015, was 76. The trust set a target of 72 for this and exceeded the target in all months between January 2015 and December 2015.

For termination of pregnancy services (ToPs)

- We noted confidentiality was observed in the busy environment of the Abortion Care service. For example, the consultants name was on the whiteboard and consulting room doors without any reference to the purpose of the clinic.
- We observed through body language and tone of voice that clinical staff in the outpatient's clinic were kind, emotionally gentle and committed to providing a good service for women with complex needs.
- This attitude was confirmed by patients we spoke with.
- However, one patient told us they were 'disappointed' that a different medical practitioner to the one they saw at the outpatient's clinic treated them when they returned as a day patient. We heard the commitment to continuity being made as the patient had agreed to participate in a medical trial.
- This patient also raised an infringement of their physical privacy due to cubicle curtains not meeting effectively during a procedure on the ward. They were not satisfied staff took it seriously at the time.
- We checked the curtain rails and noted there was a clip attached to the rail that prevented the curtain closing fully on one side, although this did not give a view to the bed. The staff nurse on duty at the time confirmed this clip should not have been in place.
- The trust told us there had been no service specific patient satisfaction audits undertaken for ToPs; the data was captured within the inpatient FFT.

Understanding and involvement of patients and those close to them

For surgery (gynaecology)

- The role of the specialist nurse included providing appropriate non-directive help and support for patients before and after termination of pregnancy.
- Patients we talked with said they were aware of the plans for their care and discharge.
- They said they were able to make their own decisions and staff listened to what they had to say. One person told us they had a lot of knowledge about their condition before they came into hospital, and they said staff always explained everything to them and discussed the options.
- They said doctors had listened to their views about their treatment, allowing them to make the decision to try a treatment even when it was not clear whether it would be successful. They said they felt they could have a full discussion with the consultant about the benefits and drawbacks. They went on to say, "They (the medical staff) know how important it is to me."
- A patient who had been admitted to the ward overnight and had then gone home for four days before returning for re-admission said, "When I went home they gave me an information pack and telephone number. I was clear about what to expect."

Surgery (gynaecology) and Termination of Pregnancy

- Some patients told us they had been given written information about their procedure or condition whilst others told us they had received verbal information, but all felt they were provided with sufficient information.
- We saw a variety of information leaflets available within gynaecology however; some were past their review date.
- Patient information was moving to the website and would no longer be provided in hard copy. Staff said they would encourage patients to go on line to read the leaflets and they were not able to print any copies for patients. Consideration did not appear to have been given to patients without internet access. This posed a risk that women will not have access to all the information they require for them to be fully informed and able to choose treatments or have the knowledge to discuss further.

For termination of pregnancy services (ToPs)

- We observed patients' partners being present and involved to the extent the patient wished in their assessment and treatment and staff facilitated this at the ToPs outpatient's clinic and on the ward.

Emotional support

For surgery (gynaecology)

- Patients were overwhelmingly positive about the emotional support they received from all the staff caring for them. A patient said, "(A nurse) has been unbelievable. It has been a very painful time for me, but they have been here for me." "I have been tearful and they have been really good." Another person said staff had been "emotionally supportive." They said, "If I was upset, I wouldn't feel silly." Others spoke of receiving emotional support from medical staff.
- Clinical nurse specialists for oncology and for gynaecology were available for patients with a diagnosis of cancer and they told us they were normally present if bad news was being conveyed to patients.
- The trust employed a team of four permanent chaplains and seven bank chaplains and these included a range of different faiths including Muslim and Church of England.
- These chaplains provided spiritual and emotional support for patients and staff. They pro-actively visited the clinical areas to increase their availability and ensure everyone was aware of the service. The chaplaincy service was accessible via the hospital switchboard if patients needed it.

For termination of pregnancy services (ToPs)

- The complex abortion care service team included a clinical nurse specialist who provided on site emotional support to patients when they were going through the procedure.
- Divisional leaders told us there was no dedicated counselling service for termination of pregnancy.
- However, they said patients could access limited counselling resources through the foetal medicine service provided by the trust. Talks were taking place at the time of our inspection about increasing the hours of the trust's bereavement service to include termination of pregnancy patient needs.

Are Surgery (gynaecology) and Termination of Pregnancy services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We found responsive requires improvement because:

- Although there was access to translation services for people for whom English was not their first language, some staff perceived the use of family members to interpret for patients to be the first option.
- We had concerns about the length of time taken to respond to delays which had been identified for patients needing surgery out of hours when a second theatre was required. Some patients admitted for termination of pregnancy were not able to be provided with a single room which they found emotionally upsetting.
- Patients with pregnancy loss or termination of pregnancy did not have the same range of options for disposal of remains as other patients/families. The bereavement and spiritual care service stated its intention to improve this.

However, we also found:

- Evidence of some learning from patients' complaints and concerns
- Services were planned and delivered to meet the needs of the local population and there was evidence of the service working with local commissioners to improve access for patients.

Surgery (gynaecology) and Termination of Pregnancy

- Quarter 1/Quarter 2 showed between January and September 2015 93% of women who were referred and had an abortion were referred for medical complexity.

Service planning and delivery to meet the needs of local people

For surgery (gynaecology)

- The extension of the early pregnancy advice unit (EPAU) to a seven day service was negotiated with the commissioners in response to demand from the local population and NICE guidance. Divisional leaders told us this was the only unit in the region which opened seven days a week.
- Relatives/partners could visit patients on the gynaecology wards between 2pm and 4.30pm and 6pm and 8pm Monday to Friday and between 2pm and 8pm at weekends. Visiting outside of these hours was at the discretion of the nurse in charge of the area.

For termination of pregnancy services (ToPs)

- The termination of pregnancy (ToP) service provided by the trust had developed beyond the previous ad hoc model in place prior to 2015. Divisional leaders described it filling a gap in local provision by providing a pathway planned with partners and stakeholders that served women with high risk and complex pregnancies.
- The complex abortion care service was formalised in to a sustainable clinic/theatre structure as a service in January 2015. It was designed to accept abortion referrals for women with medical and surgical reasons that excluded them from standalone clinics.
- The trust had changed the gestational age limit for medical and surgical terminations it would undertake. This resulted in an increased frequency of women able to access the service.
- The trust did not accept self-referrals and only offered surgical termination under local anaesthesia up to 12 weeks gestation.

Access and flow

For surgery (gynaecology)

- Patients were referred to gynaecology from GPs, community midwives, and walk - in centres, A&E or other hospitals. Self-referrals were not accepted.
- GPs had access to a consultant through the hospital switchboard.
- The EPAU was open seven days a week from 8.30am to 5.30pm on weekdays and from 8am to 1pm at weekends.
- Patients with hyperemesis and placed on the hyperemesis care pathway, were referred to the EPAU initially, but could self-refer following this if they continued to experience problems. After three spells in the unit they were seen by a consultant for review and further treatment.
- Staff in the pre-operative assessment unit saw all patients requiring elective surgery. Patients attended the unit on the same day as their outpatients' appointment or could make an appointment to attend on a different day if they wished.
- Gynaecology elective surgery was undertaken every week day. Theatre utilisation was above the trust target of 80% utilisation for every month from January 2015 to December 2015, apart from July 2015 when it was 79%. The clinical director reviewed theatre bookings to ensure theatre time was used efficiently and to ensure that gaps were left for emergency patients. This had resulted in improvements in the ability to carry out emergency surgery in a timely manner.
- A second theatre team was on call outside normal theatre hours for emergency surgery; this was shared with the midwifery service.
- Issues with the time taken to assemble the on-call team had been identified on the risk register for over five years. During this time audits had been completed and the case made for a second resident team, however, the divisional leadership team had been unable to secure an agreed date as to when the second resident team would be available. A number of different solutions to reduce the time taken to assemble the team had been explored in the intervening period, but with no improvement.
- The divisional leadership team had completed a business case and received approval at the end of 2015 for a second resident team and the aim was to have the team in place by the end of 2016. This meant there would be no improvements for eight months.
- There was a considerable increase in the number of patients admitted for elective surgery on a Thursday compared to other days of the week causing pressure on resources. This was due to two uro-gynaecology full day theatre lists occurring on the same day.

Surgery (gynaecology) and Termination of Pregnancy

- We asked why the lists could not be scheduled for different days and were told the consultants operated on complex cases and were able to support each other and work in partnership when this was necessary.
- We were told of other options which had been considered to smooth the flow, reduced the efficiency of theatre time and increased waiting lists. However, the requirement for the consultants to be available to support each other should not have meant carrying out operations on the same day.
- Patients with cancer were referred to the cancer centre for treatment or if radiotherapy was required this was undertaken at a trust very nearby.
- Only 12 patients from gynaecology had required referral for palliative care in the twelve months prior to April 2016. Six of these were referred directly to a local hospice, four were referred to the community nursing team and two were referred for end of life care as inpatients at the hospice.

For termination of pregnancy services (ToPs)

- Data collected for Quarter 1/Quarter 2 showed gestation age at the time of referral and gestation age at time of referral to the trust for complex abortion care. This showed between January and September 2015 93% of women who were referred and had an abortion were referred for medical complexities.
- Divisional leaders described the ToP's referral pathway as timely access from GP's to an independent healthcare provider to Birmingham Women's Hospital. The complex abortion care service established three outpatient clinics that ran each week.
- However, staff had identified that the pathway would be improved for patients if GP were able to refer patients with complex needs directly to the unit rather than them needing to go through the external provider.
- Trust data showed the ToP service undertook 322 medical and 278 surgical abortions during 2014/15. During 2015/16 there were 486 medical and 504 surgical abortions. This showed a significant increase in both types of treatment. Divisional leaders told us the flow varied between as few as two and as many as 12 patients admitted in one day.
- Medical terminations were provided for women up to 19 weeks plus six days and surgical terminations for women 17 weeks plus six days gestation. The trust did not provide surgical terminations for advanced gestation periods and could refer these patients to a specialist provider NHS trust although this was out of the region.
- Women who required urgent termination of pregnancy outside of these limits for medical reasons would have been referred elsewhere by the independent healthcare provider the trust contracted with.
- The service had a CQUIN 2015/16 for minimising delay in providing/accessing abortion. It aimed to offer abortion services assessment within five working days of referral and offer women the abortion procedure within five working days of the decision to proceed. For 2015/16 the trust aimed 'to record the time between referral to patient attendance at Birmingham Women's Hospital for complex abortions and improve the process where necessary.;
- The average gestation in weeks at decision to proceed [at Birmingham Women's Hospital] was eight weeks. The average time between referral to the trust and appointment across this time period was 4.5 days.
- The trust found the gestational age on referral was unknown data and difficult to collect. Internal referrals from maternity were easily tracked and patients were seen on the day or within three days of referrals.
- From this audit activity the trust found some instances in this time period where the gestational age noted on the referral (which suggested that these women were telephone triaged and seen in a stand-alone clinic) differed by 1.3 weeks. In one instance this changed the procedure from medical to surgical termination.
- The trust aimed to enable reconciliation with the recorded scanned gestational age at Birmingham Women's Hospital at the point of referral. To this end the complex abortion care service was working with the independent health care providers to ascertain from each of the referrals received and treated by the trust, when the first contact with those providers was made.
- For Quarter 3 2015/16 the CQUIN trust audit data reported the average time between first seen by a referrer and the date a referral made was 6.52 days.
- The average time between referral to the trust and the patient being seen in the complex abortion care outpatient's clinic was 5.82 days. This indicated an increase in response time from Quarter 1/Quarter 2.

Surgery (gynaecology) and Termination of Pregnancy

- The ToPs outpatient clinic saw patients referred through the contracted independent health care provider partner and offered an outpatient appointment at the earliest opportunity.
- Outpatient's clinics ran on Monday, Wednesday and Fridays and aimed to admit women as inpatients two/three days later. We followed the care and treatment of patients who attended the Wednesday clinic on the week of our visit and we saw they were admitted to the wards on the following Friday.
- We observed a system in place that ensured a patient who undertook a late medical termination of pregnancy received administration one of the medication, at the outpatient clinic and administration two, as a day or overnight patient on the ward 48 hours later.
- However, each of the seven records we looked at for patients who underwent surgical termination of pregnancy had the procedure within four to ten days of their assessment at clinic, where the long Easter bank holiday weekend intervened.
- Ward managers offered complex abortion services patients' single rooms on the gynaecology wards where possible. We noted during our unannounced visit that this was not always possible. Staff confirmed sharing a room between two women going through medical termination of pregnancy or pregnancy loss was emotionally upsetting for both patients.
- Local leaders and staff told us the potential for ToPs patients to access bereavement services offered by the trust was identified by divisional leaders as insufficient. After our visit divisional leaders opened this as a 'high' risk to be formally managed through the gynaecology division risk register.

Meeting people's individual needs

For surgery (gynaecology)

- The trust adult safeguarding lead had a lead role for patients with a learning disability. There was an alert system in the care records to identify people with a learning disability, if they had been previously admitted to hospital. This was to ensure staff were aware adjustments might be needed to enable them to access services. When patients presented in the pre-operative assessment unit discussion would take place to identify any additional support needs.
- Staff told us that they did not offer longer appointments at pre-operative assessment for people with complex needs but the appointment would take as long as necessary. They told us they had a number of very anxious patients and they tried to put them at their ease and did not set a timescale for the appointments. We saw the extended appointments given to patients who needed more time did not impact on the overall clinic time, as these appointments were planned in advance where possible and were timed at the end of the clinic.
- Staff liaised with the adult safeguarding lead when they looked after patients living with dementia or a learning disability to ensure they provided the support required and adjustments were made. They gave an example of a patient with dementia who was living at a nursing home. The adult safeguarding lead supported the service to ensure issues related to the patient's consent were managed appropriately and the ward staff were informed to ensure there was support for the person on admission.
- Translation services were available through a telephone translation service or face to face interpreters. However, we were told by staff that relatives were frequently used to interpret for patients and this appeared to be the first option for some staff. This is not in line with good practice as the accuracy of the translation cannot be ascertained. They told us relatives were able to go to theatre with the patients to provide translation.
- There were provisions to allow carers to stay overnight with the person if they wished.
- Patients with several conditions and bariatric patients were identified by the consultant at the outpatients clinic and they contacted the anaesthetist to ensure there was an anaesthetic review prior to admission if required. These patients stayed in the gynaecology extended recovery unit (GERU) for 24 hours post operatively where there were full monitoring facilities.
- The Trust had an in-house physiotherapy team but sought additional support from University Hospital, Birmingham using a purchase order. However, this was a lengthy process and it required intervention by all three members of the divisional leadership team and inevitably delays were incurred in obtaining the service. The same process was used when a specialist intravenous access team was required.

For termination of pregnancy services (ToPs)

- The ToP service provided by the trust was specifically aimed at women with high risk pregnancies and complex conditions and needs.

Surgery (gynaecology) and Termination of Pregnancy

- The trust formed an action plan in June 2015 against compliance with the Human Tissue Authority (HTA): 'Guidance on the disposal of pregnancy remains following pregnancy loss or termination March 2015.' We noted this action plan did not specifically refer to a need for the policy to address the needs of patients with learning disabilities.
- The HTA standard makes it clear that a policy needs to be presented in a way to make it understandable to all women that need to access it.
- In 2015, minutes of the trust multi-disciplinary meeting HTA/pregnancy remains recognised that patients with pregnancy loss or termination of pregnancy did not have the same range of options for disposal of remains as other patients/families. The bereavement and spiritual care service stated its intention to improve this and leaders told us a business case was in progress for extending the services' hours.
- It was difficult to determine on wards 7 and 8 when single rooms were occupied as there was no signage on the door to indicate this. Nursing staff reported they 'usually know' when a room is occupied.

Learning from complaints and concerns

For surgery (gynaecology)

- Information was displayed near the ward entrances for patients on how to raise complaints. This was also available in easy read format for people who had difficulties with the written word.
- Complaints were discussed during governance meetings and learning from complaints was circulated by email and through ward meetings
- There were 12 complaints related to gynaecology and termination of pregnancy services during 2015 where one was related to ToPs.

For termination of pregnancy services (ToPs)

- We were told of changes to the information given to patients during the consent process and changes to clinical guidelines had occurred as a result of two complaints received about the termination of pregnancy service
- Staff told us that it was only within the month prior to our visit that the trust had produced a leaflet informing patients about potentially distressing elements of late termination of pregnancy, although two similar episodes had occurred some months before. This suggested staff believed the trust had been slow to respond.
- However when we looked at the incident reports, root cause analyses, serious case reviews and improvement action plans relating to these, we noted these incidents had taken place in January, February and March 2016, only weeks before our visit.

Are Surgery (gynaecology) and Termination of Pregnancy services well-led?

Requires improvement

We found the service was requires improvement with elements of inadequate because:

- The concerns we raised in relation to infection prevention and control, and the management of medicines and intravenous fluids had not been identified in the audits undertaken within the service.
- The trust had not captured through audit the risk to breach of its condition of registration of ToP services under the Health and Social Care Act.
- Although identified through staff incident reporting, risk of staff and patient readiness for adverse elements of late gestation terminations had neither been anticipated nor formally managed by the trust.
- We had concerns about the length of time taken for the implementation of changes to take place following identification of risks and incidents.
- The priority given to gynaecology within the wider trust was perceived to be low. As a result, there were challenges in moving forward with developments and addressing risks.
- Staff and public engagement could be improved and there was little learning and sharing of ideas with other specialties within the trust.

However, we also found:

- The divisional leadership team within gynaecology showed passion and enthusiasm for improving current services and increasing the development of specialist services including the complex abortion service.

- Cultural leadership was generally good.

Vision and strategy for this service

For surgery (gynaecology)

- The divisional leadership team had developed a 'models of care' document for gynaecology which put forward a vision for the development of the service. It was produced in 2015 as an 'enabling paper for the VITA project and demonstrated the passion and enthusiasm of the leadership team in gynaecology to improve current services and introduce further specialist services. It provided a view of what could be achieved with unlimited resources and the support of the trust as a whole, and could provide a basis from which to identify the priorities for development in the current climate.
- Staff were committed to the trust and proud of the standard of care provided. They expressed their enthusiasm for the further development of the services and developing their specialisms.

For termination of pregnancy services (ToPs)

- The trust vision for the termination of pregnancy (ToP) service was to move away from a model that was ad hoc to a pathway planned within the local health economy with partners and stakeholders that served women with high risk and complex pregnancies.
- The divisional leadership team told us they were committed to developing this. Nursing and medical staff told us they were clear about this vision although some found delivering a termination service for late gestation pregnancies uncomfortable at times.

Governance, risk management and quality measurement

For surgery (gynaecology)

- The framework for governance within gynaecology had been improved during 2015/16 to make it more inclusive and improve communication within the service. The governance structure ensured performance was monitored, results discussed and actions identified to bring about improvements. We saw the minutes of governance meetings which confirmed this. Performance and outcome data was reported and monitored through the performance matrix. Any aspects where performance was below target were reviewed and timely action taken.
- A clinical improvement group met monthly. This provided a multi-disciplinary forum for the discussion of quality issues and ensured continuous improvement through the identification of future work-streams and audit priorities.
- Communication with staff to ensure learning was disseminated was variable and there was a heavy reliance on electronic communication which some staff admitted they did not always see.
- There was little information on display within the clinical areas of performance or progress in relation to quality and safety priorities.
- There were limited resources for governance within the directorate and applications had been made to the executive team for the increase in resources. There was no allocated audit time for theatres or for nursing staff. When we looked at the audit plan we found the majority of the audits were midwifery related rather than being specific to gynaecology.
- The concerns we raised in relation to infection prevention and control, and the safe storage of intravenous fluids had not been identified in the audits undertaken within the service.
- We had concerns about the length of time taken for the implementation of changes to take place following identification of risks and incidents. When we discussed some issues with the divisional leadership team they told us issues were being progressed but we found the pace of implementation slow. For example, the risk related to the requirement for a second resident out of hours theatre team had been on the risk register for a number of years with little movement. Although a way forward had recently been agreed we were told the service would not be in place until the end of 2016.

For termination of pregnancy services (ToPs)

- The new contract for the termination of pregnancy service had commenced in January 2015. At the time of the inspection in April 2016, training for staff had not been formalised despite concerns expressed by staff about the need for clarity regarding actions to be taken.
- There had been two reported incidents in February 2016 and staff told us there had been other occasions some months before when they had had concerns. However, despite the reported incidents there was still limited

written guidance for staff and no training. The serious case review (SCR) for one incident identified the need for staff training however, we noted no date had been set to achieve this on the action plan.

- In October 2014 the trust developed an operational policy for women requesting abortion care. The SCR for an incident in February 2016 identified that the procedure, pathways and guidelines needed to be updated to make them clearer and explicit particularly in relation to foetus showing 'signs of life'. These were awaiting committee approval at the time of our inspection.
- The division audited against its ToPs CQUIN for minimising delay in providing/accessing abortion and taking action including working with key partners to improve outcomes for patients. These results were reported up through the trust via governance structures for quality improvement.
- However, some risks had not been anticipated or managed for the newly established complex abortion care service. We noted no items had been opened on the divisional risk register at the time of our inspection.
- For example, staff at all levels we spoke with identified risks within the new service and had escalated concerns to their managers. Through incident reporting some actions had been put in place to manage them. These risks related to staff and patient preparedness for adverse elements of late gestation terminations.
- Also divisional leaders had not identified staff engagement with the complex abortion care service and support within the service as a sufficient concern until after our visit when they then opened this as a 'high' risk to the service.
- Divisional leaders submitted these risks to the divisional register for assessment, monitoring and mitigation within a week of our visit.
- The trust had not captured through audit a systemic omission in the completion of the legal forms HSA1, to certify the opinions of the registered medical practitioners as required by law.
- Trust leaders told us they had recently requested an external review of the new complex abortion care service as a result of an incident that generated a serious case review in early 2016.

Leadership of service

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Clinical staff felt well supported by their direct line managers and had confidence in the directorate management team who they said were visible at clinical level.
- The gynaecology leadership team demonstrated a good level of awareness of the issues and constraints within the service and were willing to personally involve themselves to overcome obstacles.
- Nurses who provided ToP care to women on wards told us the teams they worked with were good. They said women received good attention and there was a good standard of care.
- They told us leadership was good and the sisters and the ward manager were 'very good.' Some were familiar with the Head of Nursing for gynaecology and saw her frequently. They knew the Director of Nursing but were vague about leadership arrangements above that level.
- Other nurses said the Director of Nursing and other members of the executive team were not visible and they did not see them in the clinical areas.
- Within the service, staff perceived there was little support from the central trust teams, such as governance or nursing. When a member of the management team had been absent for an extended period, the staff reporting to them were not provided with support from the trust wide team.
- A further example staff gave us was in the management of the junior doctor's strike, where it was not possible to obtain accurate information from the human resources department and although meetings were set up there was no practical support. The Clinical Director regularly spent time resolving issues in relation to the rota and medical staffing.
- Staff also held a perception that decisions were sometimes made centrally without involving the directorate teams.
- Staff felt there was little sharing of ideas, systems and processes with other services in the trust and did not find any examples of learning across directorates. One person said, "It feels as though neonates, maternity and gynaecology are all working in silos."

Surgery (gynaecology) and Termination of Pregnancy

- Staff gave as an example of the senior nursing team not liaising with their midwifery colleagues to seek assistance with staff training or the development of documentation to support nurses giving care to women undergoing complex terminations of pregnancy.

Culture within the service

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- Staff were aware of the financial pressures faced by the trust and knew finances were always an issue but quality and safety were also seen as important.
- Throughout our discussions with staff and local and divisional leaders we heard midwifery services were given priority over gynaecology services, whether this was in relation to resources or clinical priorities.
- Leaders felt "held back" by a lack of resources and by having to share resources with midwifery. Staff felt frustrated by the "hoops they had to go through" to develop the service or obtain funding. A lack of resilience within the service was frequently mentioned as an issue.
- However, at clinical level, the teams worked well together and felt supported and valued by their clinical leaders. They felt proud to work at the trust and proud of the quality of care provided.
- Ward staff that cared for complex abortion patients told us they felt insufficiently supported by leaders to implement what was for some of them, a challenging and sometimes emotionally distressing new service pathway.
- They confirmed the trust had put in place a process to support their individual right to conscientious objection to ToPs and were very clear that even within this they continued to care for the patient.

Public engagement

For surgery (gynaecology) and for termination of pregnancy services (ToPs)

- The patient experience team coordinated patient and public engagement at both trust and directorate level. There had been public involvement in the development of the service's models of care strategy through the project group which was put in place to take forward the trust's vision for the development of a new hospital (VITA).

Staff engagement

For surgery (gynaecology)

- Staff mentioned the core brief (recently re-launched as 'Risky Business') as the main means of communication within the trust. They told us this was well read when it was produced in hard copy but felt it was less widely read since printed copies had not been produced. One person said, "It is incumbent on staff to access it and read it." "I am not sure everyone accesses it. It is unlikely." Staff felt they had a voice and were listened to within the service. They were aware of the financial pressures within the trust and the aim to further increase the volume of services provided. However, we did not find any evidence that they felt able to influence or have their say in the planning of services.

For termination of pregnancy services (ToPs)

- A lack of preparation and engagement prior to the start of the new complex termination of pregnancy service was apparent. Over a year after its introduction, staff continued to express concerns. Staff had been able to opt out of this service but we talked to several staff who were unhappy with the situation, including their lack of training and support. Staff talked about the distress to women and how they felt ill prepared to care for them.
- Two ward leaders we spoke with told us they felt the new ToP service pathway had been put in place at the beginning of 2015 'without much warning', 'it just happened, ward managers were informed and it suddenly happened'. One referred to it as "the beginning of it all."
- They said the service used to provide for only early gestation period termination and foetal abnormality medical problem terminations. Since spring 2015 they had been providing advanced gestation terminations, up to 19 weeks and six days and terminations for women who requested them for reasons other than foetal abnormality; staff stated: "This changed things, it put people's stress levels up massively and many people were upset"; "newer staff nurses do find it traumatic.".
- The gynaecology services risk register did not anticipate or identify this as a risk for ToPs services. After our visit we requested any updated version of the risk register relating to ToPs and noted divisional leaders had at the end of April 2016 opened staff engagement and as a 'high' risk. The target date for reduction of risk was set at the end of September 2016.

Surgery (gynaecology) and Termination of Pregnancy

- Medical trainees working within the complex abortion care service told us they greatly valued what they described as a rare opportunity to gain experience provided by placement within the trust.
- Consultants we spoke with in the complex abortion care service expressed a great commitment to provide help for women with complex pregnancies and compromised health and social circumstances.

Innovation, improvement and sustainability

For surgery (gynaecology)

- Gynaecology services had been successful in becoming an accredited British gynaecology endoscopy (BSGE) centre for complex endometriosis. This is a regional specialist service whereby women with complex endometriosis are referred and includes medical, pain related and surgical management.

For termination of pregnancy services (ToPs)

- A five year contract for providing complex abortion care had been secured. This contract covered Walsall, Wolverhampton, Sandwell and West Birmingham and South Birmingham. The trust was developing its ToPs care pathway and divisional leaders told us of plans to improve the service on offer with stakeholders and partners within the local care economy**.**
- For example, the trust aimed to be in a position to offer a 'whole package' of complex abortion care and support including counselling and contraceptive advice to improve the care pathway for women in line with national guidelines.

Neonatal services

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

Information about the service

The neonatal unit at the Birmingham Women's Hospital (BWH) consists of 41 cots. The Neonatal intensive care unit (NICU) consists of eight bays and five isolation side rooms. These areas are divided between intensive care (12 ITU cots - care for babies with the most complex problems who require constant supervision and monitoring), high dependency care (nine HDU cots- for babies who need constant monitoring) and special baby care (20 SCBU cots, although this can increase with multiple births). Neonatal surgery is not undertaken at this site. Babies who require surgery (except retinopathy of prematurity laser surgery) are transferred to a nearby children's hospital. The transitional care ward has 12 cots for babies who need extra support with care such as feeding or antibiotic therapy. This is located within the maternity department for mothers and babies to be cared for together.

The trust hosts the neonatal transport service for the West Midlands, which is a dedicated neonatal transfer team for transfers 24 hours a day 365 days a year.

We visited all areas of the neonatal intensive care unit (NICU) as part of our inspection. We observed patient care, looked at patient records, including paper records and those on the electronic data management system.

We spoke with 15 sets of parents in the unit and 32 members of staff including doctors nurses, clerical staff advance nurse practitioners domestic staff and members of the management team.

Summary of findings

Overall we rated neonatal services as 'good'. Staff reported incidents, and where lessons were learned these were shared with the staff. Training for staff was easily accessible and helped the unit work towards meeting the national recommended standards for staffing. Staff were aware of their responsibilities in regards to safeguarding.

The unit was clean and provided an appropriate environment for caring for all levels of intensive care babies. Care was evidence based and in line with good practice. Multidisciplinary working was evident throughout the unit and parent involvement was encouraged. The unit did not meet the Neonatal Audit Programme (NNAP) standards due to inconsistent data entry. Staff were identified to target improving this. Training within the unit was incorporated into daily activity.

Staff were caring and considerate to both the needs of the baby and the wider family. The management team within the neonatal unit were newly appointed or held interim posts. The responsibility for management of risks was not always obvious. The culture of the service was a supportive one with staff working flexibly to provide care. Staff felt proud to work for the service. This was reflected by the many compliments parents gave around the care babies received.

Neonatal services

Are neonatal services safe?

Good

We rated safety of the neonatal unit as 'good' because,

- Incidents were reported and investigated in a timely fashion. Information concerning incidents was shared via 'lessons of the week.'
- A daily safety huddle provided the opportunity for sharing essential information.
- In post staff training improved the number of nurses with the intensive care qualification.
- Effective use of staff improved services for families in transitional care.
- A twilight shift for doctors reduced the period of time in which the unit did not meet the minimum staffing standards. Recent employment of overseas doctors would improve compliance.
- Robust safeguarding processes were in place.

However,

- Nursing staffing did not meet the national recommended standards for neonatal unit staffing levels. The establishment of nurses meant one to one care was not always achieved for the number of intensive care babies.
- Risks identified on the unit risk register had been present for many years.
- Medical staffing cover did not meet minimum staffing standards.

Incidents

- The trust had a clear incident reporting policy in place. All staff understood their responsibilities to raise concerns, and report safety incidents and near misses on the electronic incident reporting system. Nominated members of staff reviewed the incidents each weekday morning. If required, these were discussed at the safety huddle the following day, or incorporated into the 'lessons of the week' document.
- We saw examples of incidents reported, root-cause analysis performed, and lessons learned with recommendations made. When lessons had been identified, an action plan was produced and shared within the directorate and reviewed at trust monthly patient outcomes committee meetings.
- Staff we spoke to knew how to report incidents and described the feedback they had received. They were able to tell us of changes made as a result of clinical incidents, such as an increased vigilance around medication prescribing. Changes to medication charts and teaching sessions had been increased.
- Incidents were included in the daily 'lessons of the week' handed over at the ward 'safety huddle'. Documentation of the 'lesson of the week' was kept on the safety noticeboard and available in case staff had been away for a longer period. Staff were reminded to read the notices on return to work.
- Monthly incident reporting data highlighted the top ten incidents; this was reported to the trust governance group. The most reported incident was around low staffing levels, we were told that audits were not performed around insufficient staffing incidents. However, quarterly staffing reports were submitted to the trust board.
- Between January 2015 and December 2015, 621 incidents had been reported for neonatal services. This included the neonatal unit, neonatal transport and the transitional care ward. All except one incident were low or no harm. We saw evidence of investigation and lessons learned from all incidents reported. At the time of inspection, the unit had 33 open incidents; the majority were low or no harm.
- The trust held monthly perinatal meetings attended by obstetric and neonatal staff, monitored perinatal mortality and morbidity and reported quarterly to the trust mortality and morbidity steering group, chaired by the Medical Director. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the need to be open and honest with families when things went wrong. They informed us of a duty of candour prompt within the incident reporting system, and that a duty of candour team existed within the hospital. We saw evidence of meetings with families informing them of the investigation and findings in root cause analysis action plans and letters of apology to family members.

Safety thermometer

- There was no national safety thermometer for neonatal services, however, the neonatal unit did submit data to the Southern West Midlands Maternity and New-born Network (SWMMNN). The network looked at outcomes for each neonatal unit within the network. This included the observations of numbers of babies admitted and the gestation of the baby (how far through the pregnancy they were) and reasons for admission. The episodes and degree of brain injury due to oxygen deprivation and survival rates were also monitored. In addition, the unit submitted data on numbers of babies receiving cooling treatment and outcomes of the treatment.
- Data displayed in the ward area compared current and previous month's dashboard data. Between April 2015 and December 2015, there were no incidences of pressure ulcers or avoidable new-born blood spot test repeats. The dashboard information was shared with the patient's outcomes committee (POC) each month.

Cleanliness, infection control and hygiene

- The neonatal intensive care unit (NICU) was visibly clean. We observed staff using personal protective equipment such as aprons and gloves appropriately. Hand wash sinks and hand gel were readily available. On entry to the NICU a large hand washing 'trough' with automated taps was available and all visitors were asked to wash their hands. Instructions and the National Patient Safety Agency 'clean your hands' prompt charts were in place.
- We observed good infection control practices by staff. All grades of staff were seen to clean their hands when entering or leaving the unit and between caring for each baby.
- Staff demonstrated adherence to the trust infection prevention and control policy by being bare below the elbows.
- Monthly infection prevention and control (IPC) committee reports included hand hygiene and environmental audits. Hand hygiene audits between July 2015 and December 2015 demonstrated 96% -100% compliance. If the score was below 95%, education and daily hand hygiene audits would take place.
- Between 1July 2015 and 31 December 2015, there had been eight reported cases of Methicillin-resistant Staphylococcus aureus (MRSA). Following from the first cluster of cases, outbreak meetings were held and hand washing featured as a 'lesson of the week.' Staff screening and deep cleaning processes took place. A root cause analysis was performed, routine MRSA screening of all mothers and greater vigilance around hand hygiene education took place. Between December 2015 and March 2016 there have been no further episodes of MRSA.
- The NICU had isolation rooms available in the event of caring for a baby with or at risk of an infection.
- Daily cleaning logs had been introduced by the unit IPC lead. These were visible on each of the doors for staff and parents to see. At the time of our inspection, they were completed and up to date.
- Infection control boards updated staff to correct procedures and information around IPC.
- The IPC link Lead Nurse provided support and guidance to staff and assisted with training regarding infection control issues. Staff told us they could easily contact the infection control team for advice and support.
- Data supplied by the trust demonstrated 100% of new staff had received the IPC training and 87% of current staff had completed their two yearly update.
- We saw staff cleaning equipment before and after use and applying 'I am clean stickers' on items to identify clean equipment that was ready for use. Equipment cleaners had been employed to target equipment cleaning and allow senior staff to care for the babies.
- Sink taps throughout the unit flushed automatically every hour. The laboratory staff also tested the water monthly to monitor bacteria levels within the water system.

Environment and equipment

- The neonatal unit was suitably equipped to provide care for sick and premature babies.
- Adult and neonatal resuscitation equipment was readily available throughout the unit. Emergency drugs and equipment items were appropriately packaged, stored and fit for use. Staff performed daily checks of all trolleys to confirm this.
- Babies in the neonatal unit had additional protection from an electronic tag. Security staff were automatically alerted if a baby with a tag was taken out of the unit. Staff were aware of further security measures in the event of safeguarding concerns.
- All patient equipment we looked at had been routinely safety checked and possessed a sticker demonstrating when the equipment was next due for service. A delay in equipment servicing had been identified on the risk register since 2011. This was due to a trust wide problem

of unaccounted for equipment. We did not see any equipment that was overdue for servicing. An electronic database was in use for monitoring and scheduling all medical equipment servicing.
- Clean equipment was labelled, covered and stored in a keypad locked cupboard.
- The design of the unit allowed space for staff to perform care in an uncluttered environment. Staff had performed a bed space project to streamline the use of space in one bay after evaluation. The plan was to implement the changes in all areas and included creating workbenches for clinical tasks. We saw evidence of a capital equipment replacement programme. This included a time frame and budget projection. All actions were completed within the time frame.
- Clinical waste bins were covered and had foot-opening controls. The appropriate signage was used for the disposal of clinical waste.

Medicines

- Medicines management was in line with hospital policy, for example, a new electronic key management system was on trial and proving effective in the securing of medicines including controlled drugs. The system provided an audit trail logging all access to drug cupboards. Temporary staff could be granted access for the period of their shift. Medical gases were stored in keypad locked rooms.
- Pharmacy link nurses were attached to the NICU. Training for medical staff was in progress focusing on prescribing. This was a result of an increase in drug prescribing errors. We saw data stating 89% of staff had completed the medicines management competency and 100% of the required staff had received training around the safe use of insulin. The implementation of new drug charts and staff training had reduced the number of errors from 29 in January to February 2015 to nine errors in September to October 2015. None of the errors during this period had caused harm to the babies.
- Weekly controlled drug book audits were performed. Staff displayed information on the audit on the audit noticeboard. This included the recommendation staff should bracket and initial mistakes rather than cross them out.
- To reduce medication errors we saw nursing staff wore red tabards when administrating medication. This highlighted to other staff and visitors the nurses must not be disturbed. Staff told us and we saw this working well.
- We reviewed eight drug charts and no gaps were seen against prescribing, or documenting the baby weight and allergy status. A separate prescription chart was in use for the prescribing of gentamicin (in accordance with hospital microbiology policy) and parenteral feeds. Due to the effect of gentamicin on the kidneys the prescription of the drug should be monitored closely.

Records

- Records were managed and handled safely. For example, we did not identify any unattended medical notes during our inspection. Paper notes were stored in closed cupboards in the department. The trust used a combination of paper and nationally used electronic records.
- Staff recorded a large proportion of both medical and nursing care on the electronic notes in an attempt to become paperless.
- Monthly audits had identified problems around the entry of data onto the electronic database. Staff had been appointed for taking responsibilities for improving and auditing data entry. An advance nurse practitioner was to be employed to target this in addition to looking at the National Neonatal Audit programme (NNAP) data entry.
- We looked at the records for 12 babies and found the records to be accurate and reflect the babies' care needs. All entries were dated and signed by the appropriate healthcare professional. Only one out of 12 records did not have documentation of a conversation with parents around care of the baby, we highlighted this to the unit sister/manager, and they investigated it further.

Safeguarding

- Managers and members of staff within the neonatal unit demonstrated a clear awareness of the referral process they must follow if a safeguarding concern arose.
- Data provided by the trust demonstrated that 100% of staff had received level 1 safeguarding training. Safeguarding children and young people; Intercollegiate document 2014 (a document outlining safeguarding responsibilities within the NHS), states that all clinical

staff working with children, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child, where there are safeguarding concerns should have level 3 training. Training data received during the inspection identified that 77% of staff had received level 3 training. This was better than the trust target of 75%.

- Adult safeguarding training was mandatory for all staff and 98% of staff had received level one vulnerable adult safeguarding training.
- The trust had the necessary statutory staff in post, including named nurse and named doctor. Within the neonatal unit a band six discharge liaison nurse was the department lead for safeguarding and performed additional training for all staff. All staff could describe extra support given by the named nurse in the event of safeguarding concerns.
- The safeguarding named nurse had developed discharge paperwork for babies going home or to foster care. This paperwork included safeguarding prompts and reminders to follow the correct procedure.
- Sensitive safeguarding information was kept securely in a keypad locked room. In the event of safeguarding concerns, alert prompts were in the front of all paper based medical notes and on all electronic records.
- Staff had knowledge of their responsibilities in the incidence of mothers or siblings with or at risk of female genital mutilation (FGM). The safeguarding lead and psychologist held time to talk session every week in which staff could be supported with any matter including safeguarding supervision.
- Doors to gain entry to the NICU were locked and staff gained entry via a swipe card system. Relatives used a door entry buzzer to enter the unit Receptionists were employed from 7:15am to 8.15pm to assist in answering the doors. Security cameras were present at the doors to the unit. The trust had an abduction policy and staff could explain their roles within this.
- The unit had a white board in place, which identified the names of babies, their location, their consultant and nurse. Patient confidentiality was maintained by closing the folding board when not in use.

Mandatory training

- Members of staff we spoke with confirmed that they had received mandatory training. This covered subjects such as fire, information governance, infection prevention and control, moving and handling, safeguarding, mental health, risk assessments blood transfusion and resuscitation. Trust data demonstrated a mixed compliance with mandatory training. Only 36% of staff had completed the mandatory mental health programme. Completion of neonatal life support training was 93%. A blood spot training programme was described as ongoing with 45% of staff having received training.
- Within the neonatal department staff compliance in the 60 topics covered was 81.7%. This was better than the trust target of 75%.
- Medical device training had been identified on the risk register since 2010. The NICU training compliance in February 2016 was 82% of staff for high risk medical devices and 88% of staff for low risk devices. These were better than the trust target of 75%.

Assessing and responding to patient risk

- The neonatal unit used the Neonatal Early Warning Score (NEWS) to alert clinicians to infants whose condition was deteriorating. The NEWS chart was not used for babies undergoing continuous monitoring because vital signs, pain levels and potential risks were identified through the monitoring.
- We reviewed 12 care records which showed that clinical risk assessments were completed on admission and reviewed regularly.
- Staff used a four hourly acuity tool to monitor patient workload and staffing. This included documentation of staff competencies such as ventilation training and Special Care Baby Unit (SCBU) training. Planned workload and whether the unit could accept more babies were also incorporated in the assessment.

Nursing staffing

- The lack of staffing in the unit neonatal had been on the unit risk register since 2011. The risk level had been increased to high risk due to the need to train new staff employed. High level risks were monitored monthly by the clinical incident group.
- The unit could not meet the national standards of nurse to patient ratio. The unit states that they are meeting these standards in around 75% of shifts. The current nurse to baby ratio was intensive care (ITU) 1:2 (national recommendation 1:1) although on some occasions they were able to achieve 1:1 care. The High dependency unit (HDU) staffing levels were one: two and Special Baby Care (SCBU), one: four, both of which meet national

standards. A difficulty in employing band six nurses with the neonatal intensive care qualification had not helped the staffing ratio. However, babies did receive care and treatment in a timely manner. Staff reported incidents in relation to staffing, there were no episodes in delay in care due to staffing. At the time of our visit the unit had two whole time equivalent vacancies, and two vacancies that were left open to fund bank shifts. The unit used permanent bank staff that were familiar with the service.

- During the inspection, the number of babies admitted to the intensive care unit fluctuated. There were never less than 10 babies requiring intensive 1:1 care but occasionally as many as 14. This meant that staffing numbers did not reach national recommended standards and difficult to control hour by hour. We saw evidence of the shift leader assessing the work load and staffing every four hours.
- Band five nurses who did not have the NICU post registration qualification did not care for intensive care babies.
- Nine nursing staff a year were supported to complete the qualified in speciality (QIS) neonatal qualification in conjunction with the local university. This would improve the number of staff with the qualification. The competences of the bank staff were monitored by the unit.
- Due to the unit working consistently at 100% capacity the current staffing establishment could not meet the national recommended staffing standards. This capacity is also greater than the national standards that intensive care units should plan for 80% occupancy.
- Staff told us that staffing levels did not cause them to feel unsafe caring for babies. Band seven nurses in charge did not have patients allocated to them. This ensured that senior staff could support staff and families, and concentrate on the day to day management of the unit. They were able to organise staff to receive breaks and assist staff in care. On two occasions between April 2015 and March 2015 a nurse in charge had been allocated patients due to staffing and occupancy concerns. The incident was reported in order to monitor the occurrence.
- Planned versus actual staffing levels were displayed at the entrance to the ward. We saw that the staffing levels were met for each day. Staffing rotas demonstrated the use of bank shifts to fill vacant shifts. The bank shifts were filled with the unit's own bank staff or recently retired staff. No agency staff were used.
- A staffing review was performed every six months but there had been no change in staffing numbers despite the high capacity. The nursing establishment was increased to support the implementation of 2 intensive care cots at 1:1 staffing ratio by NHS England. We were told that the Southern West Midlands Maternity and Newborn Network, which monitors the quality of care in the area, were planning to review staffing and capacity within the network hospitals.
- Nursing handovers happened three times a day. A large group overview occurred away from the clinical area including informing the staff of the more seriously ill patients, safety notices and the lessons of the week. Staff then received one to one handover beside the cots following a situation, background, assessment and recommendation (SBAR) format.
- A recent staffing review of the transitional care unit had led to a 'management of change' staffing reshuffle. Support workers were employed on the transitional care ward (ward five) to work alongside midwives to care for mothers and babies. A nurse consultant reviewed babies on transitional care ward. Midwives and support workers cared for the mothers and babies on the ward. Patients told members of the inspection team that they felt included in the care of their babies and appreciated having a named carer. They were grateful for the extra support received with breast-feeding and the care of the newborn babies.
- Within the neonatal unit, nursing staff were given non clinical shifts to performed their lead roles such as; governance lead, IPC lead, palliative care lead, safeguarding and discharge lead, developmental care lead, clinical educator, resuscitation lead, and audit and guidelines lead. The trust employed two capacity managers to look at capacity and staffing issues on a daily basis. They worked six days a week with responsibility for managing bed capacity and referrals and transfers alongside staffing.

Medical staffing

- The National framework 2014 set out suggested minimum staffing for medical staff. The standards for out of hours care should include two doctors (one tier

one and one tier two) or two advanced neonatal nurse practitioners (ANNPs), or a combination of the two. A consultant should also be available through on-call arrangements.

- The NICU had sufficient doctors and ANNPs to meet most of the national recommended standards. However, overnight standards were not met, two tier one doctors were on duty until midnight and only one from midnight until 8am. Staff told us that this did not impact on care as a tier two doctor supported the tier one doctor overnight. The consultant was not always in residence after 11pm overnight. They were however on call 24 hours a day. We were told that consultants were accessible within a 15-minute call time. In the event of a concern or an impending preterm delivery, the consultant would stay in the unit. During our inspection, we saw this happen for periods of the night.
- Newly appointed medical staff from overseas were due to be in post in September 2016. This would improve the staffing levels and ensure ompliance.
- Consultants and senior medical staff took responsibility for different clinical specialities throughout the neonatal unit. This included; a governance lead, a respiratory lead, research, simulation training, developmental lead, transitional care, safeguarding, nutrition and pharmacology, neonatal transport, newborn infections, neonatal strokes and diaphragmatic hernias, and cardiology leads.
- We saw evidence of staff consult each other for advice and support in the care of babies.
- Each day a duty bleep holder was available for medical tasks such as cannulation, blood test and tasks to prevent delays in care.
- We saw good links with the medical deanery. The medical staff told us of and we saw reports of improvements made to the support for tier one doctors.

Major incidents

- The trust had a major incident policy, and an emergency planning and preparedness and response framework (EPRR). Staff were aware of these policies and their roles in the event of an electrical or water failure.

Are neonatal services effective?

Good

We rated the effectiveness of neonatal services as good because;

- Care and treatment for babies was planned and delivered in line with current evidence based guidance.
- Parents were given advice and support in their preferred method of feeding their baby.
- Work was underway to target and improve the data entry for the Neonatal Audit Programme (NNAP).
- The neonatal unit staff were coordinated in providing care for the babies. Staff from the local children's hospital visited and coordinated care for surgical patients.
- Staff induction programmes were detailed.
- Staff who did not hold an intensive care qualification did not look after intensive care babies.
- Staff were able to access information on cot side computers.

However;

- The neonatal unit did not meet the recommended standard in five of the NNAP standards.

Evidence-based care and treatment

- The unit had systems and processes to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidence-based, best practice guidance The medical governance lead acted as the service lead for the review of guidance, and supported the incorporation into protocols where required. Clinical nursing lead was appointed to assist in the management and development of guidelines.
- The staff had access to the 162 neonatal guidelines currently in use via the trust intranet. Some of the local neonatal network guidelines had been adopted, either in part or in full. These were supported by the British Association of Perinatal Medicine guidelines.
- Clinical leads who were responsible for governance issues had alert systems in place to inform staff of guidelines due for renewal. We examined five sets of guidelines; these were in date and version controlled.
- The neonatal directorate conducted a range of clinical audits. The directorate set out 24 audits within a yearly plan. This information was stored on a registration and

management system. This plan set out the 'must do' national investigations, such as national audits. These national audits provided the information for national benchmarking such as the Neonatal National Audit (NNAP), the Picker survey and the West Midlands Service review. Examples of the audits included; an audit of the use of antibiotics and early administration; an audit of hypothermic babies admitted to the unit; the completion of the Newborn Early Warning Score (NEWS) charts; the quality of bleep messages; rhesus blood samples; the use donated breast milk; documentation of discussions with parents and an audit of the 'golden hour' for preterm baby admission. The golden hour is a term used to identify the hour after birth, when it is essential to establish early care and treatment for preterm infants, particularly less than 28 weeks gestation.

- We saw evidence of outcomes of these audits, such as recommendations that although 18 to 20% of babies still do not receive their antibiotics within the specified time frame, the reason for not administering them was always documented. This highlighted a need for training in cannula insertion for all tier one doctors. A re-audit was planned for September 2016. The NEWS audit assessed the documentation of vital signs and escalation of a deteriorating infant. It was recognised that the unit were good at completing these areas of the chart, but pain score and baby position were often omitted. Promotion of better documentation was required and a re-audit planned in June 2016.
- The database and status of the audits demonstrated the directorate's proactive approach toward audit activity, which was largely focused on the clinical outcomes for the neonates.
- The neonatal unit had achieved UNICEF level three Baby Friendly Initiative. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding. This meant that the unit had to achieve specific standards, have policies and processes in place to support these.

Nutrition and hydration

- A specialist service was provided to support the nutrition needs of babies in the neonatal unit. In co-ordination with the clinical nutritional leads, feeding advisors developed guidelines for use within the department. These included parenteral nutritional guidelines. Parenteral nutrition is a method of feeding by giving fluids and liquid nutrition directly into the bloodstream. Staff performed nutritional audits and training around the prescribing, ordering and monitoring of parenteral nutrition.
- The nursing staff completed monitoring charts for nutrition and hydration appropriately.
- Parents were supported in their chosen method of feeding. When mothers chose to breast feed but were unable to due to the baby's condition, facilities were provided for expressing breast milk in private. These were either screened areas around the bed or a designated room. Expressed breast milk was stored appropriately with a sign in log. This allowed staff and parents to tube feed the breast milk to the babies health permitting. Small colostrum (mother's first milk) packs were available at each cot side. This supplied the equipment and information necessary to support mothers in expressing colostrum as soon as possible after birth. Staff would either feed this precious milk to the baby or use it for mouth care.
- Feeding co-ordinators and trained staff were available to support and share information with parents. Information and DVDs were available for the parents on their preferred method of feeding. A new electronic book was in use with audio visual information on feeding your baby. This included expressing and breast feeding advice.
- When mothers did not want to breast feed, the unit had a range of specialist baby milks available for each baby.
- A hospital 'milk bank' was available for the provision of donated breast milk for neonates who required, but did not have available breast milk. Policies and procedures were in place for the safe administration of donated breast milk.

Pain relief

- We reviewed eight sets of records in relation to pain management and saw pain levels assessed using a Premature Infant Pain Profile (PIPP) measure. This was in accordance with the Core Standards for Pain management Service (2009) recommendations.
- The guidelines for pain management included guidance on managing care of babies receiving 'comfort care'.
- Within the neonatal department staff performed audits of the assessment of pain. We saw action plans in place such as the introduction of sucrose during potentially painful procedures on transitional care.

- Babies had access to a range of pain relief. If a baby was unsettled or appeared to be in pain, this observation and increase in PIPP score was discussed with the doctor to plan the baby's analgesia requirements.

Patient outcomes

- We reviewed information demonstrating that the neonatal intensive care unit (NICU) participated in national audits that monitored patient outcomes when applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP). Improvements had been made and four out of five of the measures were similar to the national average, although still not near to the target of 100%. The number of women receiving antenatal steroids (56%, national average 85%), was a maternity responsibility. The department identified that the shortfalls in compliance were a result of data recording failures, not a failure to comply with standards. The action plan for 2015 to 2016 included the development of an NNAP steering group consisting of medical and nursing staff. The group planned to target data entry and compliance with NNAP data. This service had not started at the time of our visit although leads had been identified.
- The unit had appointed a lead to enter data on the two-year developmental follow ups performed. This information captured the percentage of babies born before 30 weeks who have any neurodevelopmental delays.
- Trust data demonstrated that between January 2015 and November 2015, 40% of babies admitted to the neonatal unit were not premature babies.
- The trust had been selected to perform a Commissioning for Quality and Innovation (CQUIN) audit in relation to the unexpected admission of term infants to the neonatal unit. The audit was ongoing at the time of inspection, but data analysis had highlighted hypothermia (a baby being cold) as a factor, and actions had been taken to address this. These included the provision of more 'hot cots' (a cot containing a warm water filled mattress to warm a baby) within transitional care and the monitoring of delivery room temperatures.
- Unplanned neonatal readmission data for January 2015 to November 2015 highlighted a 1.4% readmission rate of neonates, this was similar to the trust target of 1.3%.

Competent staff

- The NICU had experienced difficulty employing nursing staff with a post registration qualification in specialised neonatal care (QIS). They supported staff to undertake the training whilst in post. The staff were given supernumerary (outside the usual staffing numbers) status during their assigned study time. The unit provided nine university places a year for staff to complete this training.
- At the time of our visit 70% of the registered staff held a QIS qualification. This was equal to the national recommendations. Staff without the qualification would not look after the intensive care babies.
- Clinical nurse specialists were identified who could support learning and take overall responsibility for specific areas of care. These included clinical governance, a clinical educator and educational lead, developmental care lead, resuscitation, infection control, palliative care, nutritional support and audit and guidelines.
- Staff handover sheets stated the staff competencies for each shift.
- Staff members who did not wish to complete the QIS training received other qualifications, such as caring for the ventilated infant.
- All staff were supported in providing palliative care for babies. The palliative care lead and the bereavement team provided additional training for staff. External training from The Southern West Midlands maternity and Newborn Network (SWMNN) palliative care training supported this.
- New staff described a detailed induction programme at the trust. This had been a focus of the new education lead. All new staff spent a four-week period as supernumerary, with extra time if required. Staff had a named mentor to support this period.
- Formal processes were in place to ensure medical and nursing staff had received mandatory, role specific training and an annual appraisal. Nursing staff told us that they received yearly appraisals. Information provided by the trust confirmed that by December 2015 82% of staff had received an appraisal in the last 12 months.
- All levels of staff had access to daily training. These were timetabled for between 1pm and 2pm to capture the early and late shift staff. The training included multidisciplinary simulation training with the use of high and low fidelity (basic training models or more complex programmable ones) according to the

scenario. The medical training lead facilitated scenarios on the neonatal unit, and used video technology for observing and debriefing staff. Staff described having scenarios within the birth centre to support staff learning in other areas. We saw evidence of multidisciplinary training in relation to the 'golden hour'.

Multidisciplinary working

- We saw evidence of multidisciplinary working throughout the unit. All teams were represented at the daily safety huddle to discuss the demands for the day, and share information. The neonatal pharmacist visited the ward daily. Out of hours a local trust provided neonatal pharmacy support.
- The NICU worked closely with the local children's hospital and the neonatal transfer team. We saw surgical staff from the local hospital attending daily reviews and ward rounds of the surgical pre and postoperative patients.
- Discharge planning for the baby included all members of the multidisciplinary team (MDT) involved in their care, for example, nurses, community teams, GP and therapists.
- We saw evidence of links with a local hospice and a detailed plan for transfer of a baby for comfort care. Staff also described close links with the trust bereavement team who supported the NICU lead nurse for bereavement services.
- The SWMNN Integrated comfort care pathway provided a multidisciplinary approach to palliative care. This was in accordance with national standards.
- Weekly meetings took place with the fetal medicine service to discuss pending deliveries.

Seven-day services

- Medical and nursing staff were available on the unit 24 hours a day, seven days a week. Staff duty rotas confirmed this.
- A designated pharmacist provided daily neonatal pharmacy support. If not available, an agreement was in place for on call support from a local hospital. This enabled medication changes to occur out of hours if necessary.
- Radiology support and patient transport services were a seven day 24 hour service. This included a regional transport service for babies to other units 24 hours a day. On call facilities were provided overnight.
- Twenty-four hour neonatal consultant support was in place seven days a week.

Access to information

- Cot side computers were available in the NICU and high dependency unit. Staff could access the information needed to deliver effective care and treatment.13 computers on wheels were available and used during ward rounds for access to additional information such as investigation results. Paper observation charts and family centred developmental care plans were at the foot of each cot for ongoing care.
- Staff completed detailed discharge documentation for babies transferred to other hospitals (either as a temporary or permanent transfer). A similar document for home discharges was completed. This included a detailed checklist. After recent implementation an audit was planned.
- GP's received discharge notification prior to discharge, this was then supported by discharge documentation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated that they were informed of and understood the consent process. Written consent was obtained prior to some tests or procedures. We saw four examples of completed consent forms, for example prior to laser eye surgery and prior to a patent ductus arteriosus (a blood vessel that bypasses a babies' lungs) ligation. Staff were aware of ensuring parents had a good understanding and were capable of giving consent. There was a good understanding of the need to involve other health professionals if a parent was thought to lack the capacity to provide consent.
- In one set of notes we saw an example of a do not attempt cardio pulmonary resuscitation record (DNACPR) that had previously been completed. The form was completed accurately and the date at which it was no longer in use was clearly documented. The unit audited the few DNACPR records that they had within the unit.
- Staff documented discussions with parents for the provision of donated breast milk if required.

Are neonatal services caring?

Neonatal services

Good

We rated the care in neonate services as good because,

- Parents were supported and treated with dignity and respect.
- Parents told us they felt informed and involved in their babies care.
- The service considered parents emotional needs as well as the babies' physical needs.
- Palliative care was provided to suit the families' needs.

Compassionate care

- Throughout our inspection we observed members of medical and nursing staff providing compassionate and sensitive care that met the needs of babies and their parents.
- Staff had a positive and friendly approach and explained what they were doing, for example when explaining the reason for the tubes and feeding babies.
- We observed staff greeting parents in a welcoming fashion and using the baby's name when speaking about the baby.
- We spoke with 15 parents during our visit, they told us that overall they had received excellent care and a good experience considering the circumstances. Parents said they felt listened to and were aware of the plans for the baby as much as possible. They described the staff as "empowering."
- Families commented that staff were "fantastic" and "exceptional." A mother described the staff supporting her daughter to stay with her overnight at an upsetting time. This meant a great deal to both mother and child to develop memories.
- Staff described collecting donated items for families with very little to provide much needed baby items. The trust supported the process by providing an area for storage of these items.
- During difficult times staff protected parents' privacy with screens or use of quiet areas. Babies were treated with respect at all times.
- Parent's wishes were considered throughout care in the NICU, but especially during 'comfort care.' Where possible the family were encouraged to stay within the unit to be close to their baby at the end of life.
- Spiritual support was available for all religious beliefs through the chaplaincy service. This included teams of volunteers trained in providing bereavement support and counselling. The parent's cultural and personal wishes were accommodated in preparing a baby after death.

Understanding and involvement of patients and those close to them

- Parents told us they had been involved in the care and treatment their baby had received. This was confirmed in the Neonatal survey 2014, where 86% of parents felt involved with their baby's care, in line with the national average. We saw parents being involved and supported in caring for their babies.
- Parents told us during difficult and uncertain times they felt part of the team even when the outcome was uncertain.
- We saw parents given choices around palliative care. These were tailored to the parent's wishes and referred to as 'comfort care.'
- Staff acknowledged that having a baby in the NICU was a stressful time. We witnessed clerical staff discussing staying in the trust parent flats and were compassionate and sensitive to the couple's needs.
- The NHS England Neonatal 2014 (Picker survey) results demonstrated the unit could improve on the involvement of parents. The unit scored 77 which was the same as the survey average of 77 but worse than the top scores of 88. The education team, family centred, and development team had plans to involve the Clinical Psychologist in training on supporting parents.

Emotional support

- Results from the Picker survey 2014 demonstrated that 92% of parents said 'yes' when asked 'did you have confidence and trust in the staff caring for you baby?' This was similar to other services within the survey (survey range: 89-94%).
- Three times a week a Clinical Psychologist visited the unit and made a particular effort to speak with all parents. They liaised with staff to identify the more vulnerable parents during the visits.
- Sessions providing tea and a time to chat were arranged for parents to share experiences and ask questions in a non-intimidating environment.

Neonatal services

- The unit provided chaplaincy team support for parents. This multi-faith service also offered on call facilities.
- The Bereavement Team had been developed to provide support to parents and staff. Staff expressed that since the training they felt more prepared for supporting families. The counsellor within the unit planned to provide training for members of staff in basic counselling skills.

Are neonatal services responsive?

Good

We rated the responsiveness of the neonatal services as good because,

- The neonatal unit worked with the local neonatal network to ensure babies received care in the most appropriate location. Bed capacity managers were employed to support this.
- Four hourly monitoring of workload and patient movement identified access and flow through the unit.
- Parents were involved in planning and agreeing their babies care.
- The unit encouraged parent feedback and responded to complaints.

However, we also saw;

- The local neonatal network were reviewing the capacity within the network as Birmingham Women's Hospital (BWH) would at times be at 113% capacity.

Service planning and delivery to meet the needs of local people

- Where possible, the neonatal intensive care unit (NICU) supported other NHS trusts when babies needed more specialist care and treatment.
- The unit currently had 41 cots and also had the space for further cots.
- The local neonatal network were reviewing the capacity within the network as Birmingham Women's Hospital (BWH) would at times be at 113% capacity.
- Bed capacity managers were responsible for accepting and organising transfers of babies to their local neonatal units. Having the leads for this service ensured co-ordinated planning and audit trails were maintained. The staff aimed to ensure babies were cared for in the most appropriate neonatal unit.
- Staff worked closely with families to care for babies near the end of their life in the most appropriate place. Parents were given choices and were involved in planning the care of their family. This included a close working relationship with local hospices.

Access and flow

- Daily safety huddle meetings discussed the current bed capacity and potential patient flow through the unit.
- Detailed handover sheets highlighted potential workload and actual activity. This was reviewed every four hours to monitor access and flow through the unit.
- Bed capacity leads worked six days a week to organise patient transfers and admissions. The unit did not close to patients in need of admission, but would at times have to delay ex-utero (babies already born) transfers until cots were vacant, and staffing levels were appropriate.
- Staff described this as a process of redirecting patients. When the bed capacity staff were not available, staff maintained documentation of accepted, redirected or babies refused admission. The staff did not redirect or refuse a baby that was already within the hospital. The safety of the babies within the unit was considered at all times.
- The NICU was the tertiary unit for neonatal surgical care. Babies were admitted pre and post operatively, receiving surgical intervention and immediate neonatal intensive care in a local children's hospital. The hospital also received referrals for diaphragmatic hernias as the specialist hospital.
- The neonatal unit managers led transitional care (ward five).Transitional care is a ward for babies needing extra care or support, such as with medication or feeding problems. A Consultant Nurse was responsible for leading the care and treatment of the babies. This enhanced the continuity of care for these babies and ensured consistent information for the families.
- Midwives and care support workers were employed to work solely on ward five.
- The NICU service was commissioned to provide 90% cot occupancy. Between BWH provided a neonatal transport service for babies to and from the West Midlands area. This did not include a baby stabilisation service. There were procedures in place should a babies condition deteriorate in transit. A comprehensive neonatal team of 16 trained staff were responsible for the transport service.

Neonatal services

Meeting people's individual needs

- We saw discharge planning pathways in place. A discharge planning nurse worked five days a week to co-ordinate discharge plans and support for parents.
- We tracked one baby's pathway and saw that discharge planning had commenced from admission to the neonatal unit. The baby's records confirmed that the parents were involved in the discharge process. The document confirmed that parents had completed the resuscitation training.
- Equality and diversity training was mandatory for staff. Data received demonstrated that 95% of staff had completed their equality and diversity training.
- The electronic notes included the parent's preferred language.
- Parents and families accessed spiritual support through the multi-faith service provided by the chaplaincy team within the hospital.
- Six parent flats were available close to the NICU for families to stay near to their baby. Staff understood that at times there were not enough flats and had to prioritise for parents who did not live close to the hospital.
- A parent's sitting room was available with toys for siblings. Within the parent's sitting room, parents could use a kitchenette for refreshments.
- Staff were aware of resources and support available for parents with learning disabilities. Staff told us the video information books would be beneficial under those circumstances. Screens provided privacy for parents whilst giving skin-to-skin care to their baby.
- A variety of neonatal outpatient clinics were provided. Staff provided a variety of outpatient services; these were both doctor and nurse led. For example, neurology, physiotherapy, prolonged jaundice, ophthalmology, renal, cardiac and low birth weight clinics.
- The trust provided link workers for interpreting services. They also used bank interpreters in combination with national services.
- Leaflets were in the process of being produced to explain to parents some of the feelings they may experience whilst their baby is on the NICU.
- We saw staff using quieter rooms to spend time with parents after difficult moments.

Learning from complaints and concerns

- The inspection team saw feedback to relatives around a complaint. This led the family to several contacts to discuss the complaint including the patient advice and liaison team. There was also a public apology for 'letting the relatives down.'
- Between January 2015 and December 2015 the unit had received and responded appropriately to 5 complaints. We saw evidence of training actions and recommendations for staff around using training videos to improve staff communication skills.

Are neonatal services well-led?

Good

We rated the leadership within the neonatal unit as good because;

- Governance arrangements were in place. Staff explained how each meeting linked to wider committees and why.
- We observed a very good relationship between clinical staff and NICU managerial staff. The unit managers described a good relationship with the executive managers.
- The leadership of the unit was proactive and supportive.
- Staff described a culture of openness and learning.
- Parents were included in developments within the unit.
- The developmental care model enhanced the developmental wellbeing of babies in the unit.
- A culture of openness, flexibility and willingness was demonstrated amongst all the teams and staff we met.
- Information was captured from parents through the use of a glad/sad comment board. Relatives were encouraged to post anonymous notes containing comments on a board in the unit.

However we also saw;

- Risks, issues and poor performance were not always dealt with appropriately or in a timely way.
- Governance meetings and performance management were not always effective due to the expectations of the meetings. Many topics were incorporated into long meetings.
- Responsibility for risks were not always apparent.
- Capacity data was collected but not acted upon.

Vision and strategy for this service

Neonatal services

- The directorate strategy was to deliver an excellent experience that exceeded a parent's expectations.
- Their wider strategy within the neonatal intensive care unit (NICU) was to care for the right babies in the best place and never have to turn a baby who needed care away. Staff planned for the unit to provide complete family focused care and viewed the merger with a children's trust as a step in the right direction to achieve this. During our visit, staff throughout the unit echoed this.
- The ethos of the right care in the best place was also evident in palliative care for babies. The board representative for end of life care worked closely with bereavement teams throughout the hospital.
- The development of bereavement teams and family support was part of the family centred care ethos.
- The neonatal unit set performance targets to meet and considered all strategies to achieve this.

Governance, risk management and quality measurement

- Governance arrangements were in place. Staff explained how each meeting linked to wider committees and why. Staff described how the directorate clinical improvement group fed to the patient outcome committee, but appeared to be unsure of where and with whom, the ultimate responsibility for governance sat. This was possibly due to many of the management staff being recently appointed or had interim posts.
- A risk register was in place highlighting the unit's greatest risks. At the time of inspection, 21 risks were placed on the neonatal register. Four of these risks were considered high-level risks. The risks were drug cupboard keys, medical device training, high bed occupancy rates and risks to implementation of the review of transitional care provision. This risk was combined with the final risk of a shortage of nurses and midwives. There was evidence of reviews of the risks and actions taken, although some of the risks had been on the register for up to six years. Ultimate responsibility for the risk register did not sit with one individual making the review and removal of items lengthy. When discussed with the managers they expressed that final review and responsibility for the risks was at times protracted.
- Neonatal staff held monthly clinical improvement group meetings. Minutes of meetings showed that the nursing and consultant leads, and clinical governance lead attended them. The minutes documented discussion on a range of issues in relation to the NICU and actions noted. For example, the minutes described actions around training of tier one doctors on 'golden hour', sharing on guideline changes and implementation of pressure area risk assessments. Clinical incidents, the risk register, complaints, infection control, guidelines, infection control, audits, training, the neonatal dashboard and developmental feedback were all discussed at this meeting. Due to the large remit of the group, agendas for these meetings were long. Action plans were developed and fed back to staff via email and safety huddles/handovers.
- The unit had systems in place for policy development and approval.
- The NICU risk register identified risks; however consequences were not always apparent. The responsible individual updated the controls/actions taken but a formal action plan was not always evident. For example, a need had been identified to resolve the pressure on tier one doctors to perform newborn examinations. This had been in progress for five years. There appeared to be no correlation between the action and reducing the risk. When questioned, staff were not aware who held the responsibility for this risk or others on the register.
- We did see evidence of more timely actions around some risks such as the time spent looking for controlled drug keys having a negative impact on patient care. At the time of inspection, a trial was underway of a new secure key system. This risk had been addressed within twelve months.

A programme was in place for addressing extreme, high, medium and low risks on the register. This did not explain responsibilities or highlight a time frame for actions.

Leadership of service

- We observed a very good relationship between clinical staff and NICU managerial staff. The unit managers described a good relationship with the executive managers. All other staff described both clinical and non-clinical NICU managers as very supportive and approachable.
- Throughout our visit we saw all the clinical managers working alongside colleagues during some busy periods.

- At the time of our visit, the management team were new and two of the four managers held interim posts due to a staffing reshuffle.
- The three directorate managers reported to different members of the management structure. This prevented a lack of a clear line of reporting and responsibilities. For example, responsibilities for the risk register were shared by many managers although decisions to remove or retain risks were unclear.
- The NICU service was commissioned to provide 90% cot occupancy. Between BWH provided a neonatal transport service for babies to and from the West Midlands area.

Culture within the service

- A culture of openness, flexibility and willingness was demonstrated amongst all the teams and staff we met. Staff spoke positively about their service although concerns were raised around capacity and staffing levels.
- The neonatal unit had a reporting culture. Staff told us they had no hesitation in reporting incidents and following trust policy. They felt assured that managers responded appropriately to reported incidents.
- The trust employed a Duty of Candour manager who supported training for staff. This included recognising their responsibilities around recognising harm and providing truthful information, support for families, and an apology when things went wrong. The manager linked closely with governance leads to provide support during the process.
- The unit promoted a culture of family centred care with the development of the 'family centred developmental care round.' Staff used the care round to highlight that the family involvement and development of the neonate was as important as the care babies received.
- Staff told us they were very proud to work at the unit and felt they were giving excellent care.

Public and staff engagement

- Information was captured from parents through the use of a glad/sad comment board. Relatives were encouraged to post anonymous notes containing comments on a board in the unit. For example: 'nurses are really helpful' and 'good verbal reassurance and advice' or comments on the environment 'the units are always so clean' or 'the parents' room is lovely.' Parents used this opportunity to ask for recliner chairs by the cots and for zero size nappies to be sold in pharmacy and both these areas were addressed.
- Feedback received from friends and family data fluctuated. The unit manager explained this was due to not capturing information from all parents. The feedback response was between 3% and 19% of babies admitted to the NICU. We saw a focus on staff involvement to improve the number of responses received. Staff received email feedback from the patient experience lead nurse. This included naming staff who had received comments and thanks from parents and family. We saw evidence of staff feeling positive and motivated by these comments. The league table approach to the comments appeared to help staff to understand the value of the feedback. At the time of our inspection, there was no data for the March friends and family test data visible on the ward information board. This was due to awaiting collection by the staff.
- The trust had introduced a new Family and Patient Advisory Council (FPAC). This was in the process of developing roles and responsibilities.
- Parents and staff were involved with improvements to the NICU, these included changing the chairs around the cots and altering the visiting hours.
- Staff held weekly parent support meetings called 'tea at two', giving parents a chance to meet each other and members of staff.
- Staff had recently introduced monthly 'time to talk sessions.' This did not have a fixed agenda but allowed staff to discuss concerns and issues from work in a safe non-challenging environment.
- Staff attended 'stand up solutions meetings' to discuss unit issues. Minutes were not kept from these meetings. Staff away days occurred in September and February giving the department chance to feedback changes and gain feedback from staff. We saw evidence of discussions around capacity management and communication within the clinical team.
- Staff told us management teams performed a walk around to review staffing and capacity issues and enable staff to report concerns.

Innovation, improvement and sustainability

- Staff spoke positively around the future merger of Birmingham Women's hospital and Birmingham

Children's Hospital. They saw this as an extension of family centred care and a proactive measure to use resources and sustain a first class service. They were realistic about the demands that this would cause.

- The NICU have implemented a family centred developmental care model. This was an innovative model of care researched in Canada. This involved parents in the care of their babies. The use of this model within hospitals in the United Kingdom is quite limited.
- Staff introduced the routine use of pulse oximetry for all babies within 24 hours of birth or prior to discharge. This has been identified as significant in the early detection of critical congenital heart defects prior to the deterioration of the baby. The business case and rationale for testing has been shared nationally. Nationally around 20% of hospitals currently routinely perform this test.
- The implementation of a new electronic key control system for drug cupboards had reduced time spent looking for the drug keys.
- Research links within the unit were strong with many projects ongoing.
- The unit maintained close links and collaborative working with the new-born network and this was supported by a unit consultant present as clinical lead for the network.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

A range of outpatient services are provided by Birmingham Women's NHS Foundation Trust which include: maternity antenatal and gynaecology clinics, urogynaecology, colposcopy, hysteroscopy, neonatal, foetal medicine and physiotherapy clinics. In 2014/15 there were 135,457 outpatient appointments.

The diagnostic imaging department provides a number of diagnostic services to the patients of Birmingham Women's Hospital including general x-ray and sonography (a diagnostic imaging technique to see internal body structures such as tendons, muscles, joints, vessels and internal organs).

During our inspection we visited the outpatient and diagnostic imaging departments on 13 and 14 April 2016 and spoke to 26 patients, three senior managers, one doctor, seven clinic/department managers, two physiotherapists, seven nurses, two sonographers, two radiologists, two receptionists, one healthcare assistant and we reviewed 11 patient records. We did not visit foetal medicine as this area was not included as part of our inspection remit.

We observed care and received comments from our focus groups from staff, patients and the public directly. We also reviewed the systems and management of the departments including the performance information.

Summary of findings

We rated this service as 'requires improvement' because,

- There were poor pathways in the antenatal clinic resulting in excessive waits for patients up to five hours for multiple appointments.
- The excessive waiting times in the antenatal clinic were not on the risk register and there was no monitoring system in place to assess the waiting times within clinics.
- Challenges to recruit sonographers.
- The radiology department appointment system was also not fit for purpose; patients who required a 30 minute scan appointment for their 20 week pregnancy were allotted 20 minutes instead. This created a backlog of appointments and long waiting times in the department.
- Staff within the radiology department regularly worked late to ensure they saw patients who were waiting up to two hours.
- The trust was aware of the challenges of the pathway in the antenatal model of care and had commenced a re-evaluation. However, there was no definitive timescales for completion within their action plan.
- Staff highlighted risks, which were not on their risk register such as environmental constraints of 'space' to accommodate the increasing number of patients.

Outpatients and diagnostic imaging

However we also saw,

- Staff had a good understanding of the incident reporting process. Staff shared learning from incidents and gave examples of changes in practice in response to reported incidents.
- Staff followed the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) when making decisions about patients with disabilities and mental health issues.
- Staff had effective supervision, appraisals were up to date and they were motivated to continue to update their professional development.
- Staff provided a caring and compassionate service to patients. Patients also confirmed this to us in addition to reviewing the NHS Friends and Family Test (FFT) questionnaire.
- The radiology department responded to patients with a high BMI (body mass index) as they had a scan room with a bariatric bed.
- We saw a clear vision within the outpatients and diagnostic imaging services departments.
- All staff understood the hospitals strategic plan and was positive about the forthcoming merger with Birmingham Children's Hospital.
- There was clear leadership in both the outpatients and diagnostic imaging services.
- Staff felt supported by their managers who were visible on the departments and provided an open door policy.
- There were examples of innovative practice in both the outpatients and diagnostic imaging services. Staff were proud of the hyperemesis (severe or prolonged vomiting) unit, acute 'one stop' gynaecology clinic, home birth team pilot and the e-learning package in conjunction with the Liverpool Women's Hospital. This measured the safe use of insulin and other initiatives to 'stop smoking' to reduce cervical cancer.

Are outpatient and diagnostic imaging services safe?

Good

We rated the services safe domain as 'good' because,

- Staff understood the processes involved to protect patients from abuse and avoidable harm.
- The incident reporting process was effective and embedded across all services and staff felt supported to raise concerns. Staff shared learning and gave examples of changes in practice in response to reported incidents, for example learning to double check a patients details before cancelling an appointment if it involved patients with the same name.
- The cleanliness and hygiene in the department was of a good standard and was supported by regular hand hygiene audits, which showed high levels of compliance.
- Patient records in outpatients and diagnostics were available for all clinics.
- Staff were positive about mandatory training, which was well attended.
- Staff had a good understanding of the policies and procedures to protect and safeguard children and adults. Training figures showed most staff had completed training in safeguarding for both children and adults.
- Although, the diagnostic imaging department had low staffing levels, it used agency staff to cover their shortages to deliver the service to patients.

Incidents

Outpatients

- Staff we spoke with demonstrated a good knowledge and understanding of the trust incident reporting system. Staff knew the different levels of harm for example low, moderate and severe harm and knew when to escalate incidents to the senior management team.
- A total of 550 incidents had been reported between February 2015 and February 2016. Of these, 76 resulted in no harm, 210 low harm, 242 moderate harm and five as severe harm.

- Three serious incidents required investigation. These included radiology and scanning incident, information governance breach within the neonatal baby clinic and a manual handling incident within the gynaecology outpatients department.
- There had been no 'never events' (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in the outpatients department during the preceding 12 months
- Staff discussed lessons learned at team and departmental meetings and we saw minutes of these meetings. For example, a receptionist had cancelled a patient's clinic appointment by mistake due to duplicate names on the clinic list.
- The lessons learned resulted in a change of practice, which included a patients' date of birth and address should be double checked before appointments were cancelled.

Diagnostic and Imaging Services

- The managers told us they encouraged an open culture of incident reporting across all of the diagnostic departments and staff we spoke with confirmed this.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the hospital incident reporting system. Staff discussed incidents at departmental governance meetings, and meeting minutes supported this.
- There had been no 'never events' in the radiology department during the preceding 12 months.
- Multi-disciplinary team Meetings (MDT) were in place to learn from incidents.
- Staff demonstrated adherence to the duty of candour regulation within the radiology department. For example, staff were wearing latex gloves which caused a patient to have a reaction (a rash). Staff told us they followed the duty of candour procedure by apologising to patients and explained their actions fully.
- Ionising Radiation (Medical Exposure) Regulations IR(ME)R incidents were reported to the medical physics team who reviewed the incidents and actions were implemented when appropriate.
- The trust also notified us of three IR(ME)R incidents between January 2014 and 2016. These went directly to the national IR(ME)R team at CQC, who assessed them and were closed off.

Cleanliness, infection control and hygiene

Outpatients

- Waiting rooms and the outpatient's clinic rooms were observed to be clean.
- We observed staff complied with the trust policy of being bare below the elbow. Clinical staff adhered to having their sleeves rolled up to above the elbow with no jewellery or watches other than a plain wedding band.
- Staff we spoke with demonstrated a knowledge and understanding of cleanliness and control of infection. Records showed a compliance rate of 90.1% of staff had received infection prevention and control training against a trust target of 85%.
- Records provided by the trust demonstrated 100% of staff had received training in hand hygiene. The hand hygiene audit completed in April, May and June 2016 showed 100% compliance within the colposcopy outpatients department.
- We saw staff that washed their hands and used hand gels.
- Staff requested patients use the hand gel on entering clinical areas and was available in all clinical areas.
- We saw green 'I am clean labels' on equipment in outpatients and electrical safety and regular maintenance checks were being carried out by staff which was being recorded.

Diagnostics and Imaging Services

- Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. The department was visibly clean.
- A nominated infection control radiographer attended monthly infection control meetings. The Clinical Lead told us staff saw patients with a known infection such as MRSA at the end of the day. Domestic staff deep cleaned any infectious areas and a notice sign was visible on the door to stop any further scans until cleaned.
- Records showed 72.7% of staff had completed infection prevention control training against a trust target of 85%. We observed staff following infection control measures by washing their hands and using protective gloves and aprons when providing care or coming into physical contact with patients.

- Hand hygiene audit data for the radiology department overall was 98.2% for 2015 to 2016. Results showed from the last 3 months in 2016 were, 100% for January, 95% for February and 100% for March.

Environment and equipment

Outpatients

- The waiting areas in outpatients were large, well-lit with natural lighting and clean throughout the areas we inspected. All outpatient areas we visited were tidy, including corridors. The atmosphere was generally calm, even where the clinics were very busy.
- Staff maintained privacy when dealing with patient's confidential information at the reception desk. Staff photographs were visible for easy identification.
- Staff cleaned and checked the safety of toys each day.
- We saw green 'I am clean labels' on all equipment in outpatients. Equipment was electrical safety tested and regular maintenance checks were being carried out by staff that was recorded. Staff were up to date on training on all equipment in clinic rooms.
- Maintenance contracts were in place to ensure specialist equipment in the outpatient and imaging departments were serviced regularly and faults were repaired quickly.
- All resuscitation trolleys had sealed units, were visibly clean and in good order. Staff checked the equipment on the top and signed the appropriate check form daily.
- The clinic rooms within outpatients were clean and we saw cleaning schedules in each room were fully completed.
- We saw good evidence of the management of waste and clinical specimens, which included segregation, labelling, handling and appropriate treatment and disposal of waste.
- Staff carried out regular audits within outpatients, for example, the 'evidence of equipment maintenance assurance and environmental audits' were recorded and up-to-date in the last 12 months.
- The Clinical Lead explained the plan of changing the phlebotomy clinic to a unit with a ticket system, which would increase space.
- Staff were up to date on training on all equipment in clinic rooms.

Diagnostics and Imaging Services

- The radiology department had adequate number of Radiation Protection Supervisors (RPS) and a Radiation Protection Adviser (RPA) who advised on all aspects of radiation safety.
- Staff regularly checked, cleaned and audited the sonography equipment. Slave monitors (monitors at the end of patient beds) were available in obstetrics rooms so patients could see their babies.
- The radiology team checked the resuscitation equipment daily and records were up to date.
- The trust presentation highlighted that obesity is a problem within the local population. We observed a bariatric bed in one of the scan rooms available for patients with a high BMI rate.
- Within all areas of the sonography department we found doors and cleaning cupboards were securely locked.
- Monthly and quarterly equipment and environment audits were in place and staff used personal protective equipment when required.
- We found the diagnostic imaging rooms were generally small. The Clinical Lead was aware of the environment and building constraints having an impact on current patient throughout and the service was seeing an increasing number of patients in the department.

Medicines

Outpatients and Diagnostics Services

- There were robust systems in place for managing and dispensing medication to patients who attended the outpatient and diagnostic departments.
- In the antenatal clinic, the medicine store room was not locked and medicines requiring cool storage were stored in an unlocked medicine refrigerator.
- Controlled drugs were not stored in the main outpatient department.
- Medication trolleys were up to date and checked consistently throughout the department by audit. We reviewed the audits to see that they reflected this. Medication was within its expiry date.
- Staff followed NICE guidelines for medication management within outpatients and diagnostics services.
- There were no monitoring ranges for fridge temperature checks in the baby neonatal outpatients department. We observed records where staff reported the

temperature as 9 degrees celsius on two occasions: 24 and 25 March 2016. However, staff took no actions despite the recommended temperature medicines should be stored at is between 2 to 8 degrees celsius.
- However, during the unannounced visit on 25 April 2016 we saw visible standard operating procedures (SOP) with a flow chart for all fridges, which contained flu vaccinations. It included the processes for checking the temperatures and actions required if the temperatures were out of range including actions to take during out-of-hours. Staff were using this process and checks were being done.

Records

Outpatients

- The outpatient department used both paper and electronic records. Clinicians reported no problems accessing either version.
- However, if patient records were not available, staff told us they would make every attempt to locate the record, and in the event of a lost record, staff made a temporary record.
- We reviewed 11 sets of patient records across all areas of outpatient services. All records were legible, contained up-to-date typed letters, completed consent forms and demonstrated patient engagement.

Diagnostic and Imaging Services

- Staff informed us within diagnostics and imaging services, they had a Picture Archiving and Communication System (PACS) administrator who administered the records of patient's images and scans. This provided an accurate system to monitor patient scans.
- Staff told us about an electronic database of the Radiology Information System (RIS). Staff accessed this for patient information, recorded their doses, and reviewed their records.

Safeguarding

Outpatients

- Staff within all areas of outpatient clinics was aware of their roles and responsibilities relating to safeguarding and knew how to raise matters of concern appropriately. They understood their role in protecting children and vulnerable adults.
- Staff within outpatients were up-to-date with their safeguarding training. Records showed 98.9% of staff had received adult safeguarding level 1 training and 100% of staff were trained in children safeguarding level 1. The trust target was 95%. In addition, 93% of staff had completed level 2 safeguarding in adults and 74.6% of staff had completed level 2 safeguarding children training, against a trust target of 85%. Level 3 safeguarding was 92% for the maternity directorate, 91% neonatal and 91% gynaecology against a trust target of 85%.
- Staff were aware of female genital mutilation (FGM) processes learned during safeguarding training and explained what action they would take if this was suspected.
- Staff accessed information and advice from the trust safeguarding team and the safeguarding policy was available on the intranet.

Diagnostics and Imaging Services

- Staff were up to date with their safeguarding training in children and adults level 1 where records showed compliance of 100% against a trust target of 95%.
- Records showed that 68.4% of staff had completed safeguarding in children level 2 against a trust target of 85%. Data received from the trust stated they were not required to complete safeguarding in adults level 2. There was no specific level 3 safeguarding data for the radiology department but rather was embedded across the maternity, neonatal and gynaecology directorates.

Mandatory training

Outpatients

- Records demonstrated 84.4% of staff had completed their mandatory training within outpatients and diagnostic services against a trust target of 85%.
- Staff were given mandatory training on a rolling annual programme within the outpatient and diagnostic services. They were able to access online courses as well as face-to-face training.
- Staff accessed their mandatory training such as basic life support, infection control, safeguarding and health and safety. Managers released a monthly report to keep staff informed if training was due and to check who was up-to-date.

Diagnostics and Imaging Services

Outpatients and diagnostic imaging

- A Lead Sonographer told us staff received their departmental induction training as well as specific agency mandatory training.
- Within outpatients and diagnostics there was a system of block mandatory training available so staff could complete any outstanding training.

Assessing and responding to patient risk

Outpatients

- Resuscitation equipment was readily available throughout the department. We observed staff regularly checking the equipment by signing the appropriate check form and ensuring it was within the expiry date, we saw the record book was up to date.
- Staff had clear guidance to follow should a patient's condition deteriorate within all outpatient areas. The Lead Matron for the day assessment unit informed us they responded to emergencies by dialling the trusts adult resuscitation team who could transfer patients to the delivery suite.
- Across all directorates, 87.8% of staff had completed their mandatory training on Adult Basic Life Support Training (ABLS) against a national guideline of 85%.

Diagnostics and Imaging Services

- Diagnostics and Imaging services had resuscitation equipment available. Staff checked this regularly and was supported by an up-to-date record book.
- There were signs displayed in the radiation department waiting area and X-Ray room to inform people where radiation exposure took place. The service did not expose pregnant women to radiation as the ultrasound rooms did not contain any radiation and staff adhered to pregnancy checks.
- Two Radiation Protection Supervisors were available and ensured that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- A band five radiographer informed us a RPA monitored and responded to non-accidental injuries. They benchmarked protocols from the Birmingham Children's Hospital.
- Staff checked the six points of Patient, Anatomy, User Checks, Systems/Settings, Exposure, and Draw to close (PAUSED) checklist, which was displayed on notice boards when checking non-surgical interventional radiology patients.
- There were processes in place to ensure the right person was getting the radiological investigation at the right time. A shift leader co-ordinated scans and joint working was involved when scans were performed.
- Other systems were in place including an on-call system managed by radiographers running from 5.30pm to 8.30am to respond to patient risks.
- However, sonographers mentioned patients with large BMIs could cause sonographers more Repetitive Strain Injuries (RSI). Although, a bariatric couch was available for patients with high BMIs, it did not assist sonographers with scanning. The senior managers were looking into this issue.

Nursing staffing

Outpatients

- Agency staff were not used, as nurse staffing levels met the needs of patients within the outpatients department. Staff worked extra hours to cover staff absences.
- Staffing levels within colposcopy were good and the department had advertised for a new co-ordinator to manage the team and the service.
- However, two physiotherapists covered the physiotherapy department's reception on Fridays due to a shortage of receptionists. Staff were waiting for a plan for a volunteer to work on the reception on Fridays to remove this additional role from the physiotherapists.
- The staffing within outpatients contained a skill mix of specialist nurses, consultants, healthcare assistants, midwives, sonographers, radiologists and administrative staff.

Medical staffing

Outpatients

- The individual specialties arranged medical cover for their clinics. Staff managed medical cover within each clinical directorate who agreed the structure of their clinics and ensured they were not overbooked.
- A rota co-ordinator managed medical consultants and other specialists by a rota system.

Outpatients and diagnostic imaging

- The antenatal clinic followed good practice that used regular locum medical staff who all had received an induction process.

Diagnostics and Imaging Services

- Staffing was generally low within the diagnostics and imaging services and was on their risk register. The department struggled to recruit sonographers and this was a problem within radiology departments nationally. They block booked agency staff that was familiar with the department. The department included eight sonographers, 50% of which were agency staff.
- The out-of-hours on-call system involved staff working from home 5pm until 8.30am to respond to emergency scans. It was also on their risk register due to not having enough staff to cover it. The department had attempted to recruit two more sonographers since October 2015, but had been unsuccessful.
- Nationally, recruitment of sonographers is a challenge. The radiology department informed us about an initiative to increase pay for sonographers to generate more interest.

Major incident awareness and training

- Staff described their roles and responsibilities should a major incident occur from both outpatients and diagnostics services. Staff were able to tell us the processes involved and who to contact during an emergency situation.
- Trust induction and mandatory training included major incident training.
- Staff were used flexibly across departments when there were staffing issues or major incidents that required additional staff support.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected this domain however we did not rate it,

- Each speciality clinic conducted audits and made decisions about patients in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff followed best practice when making decisions about patients with disabilities and mental health issues.
- Staff with appropriate skills and training worked across areas of outpatients and diagnostic services.
- Staff received inductions and comprehensive training for their roles.
- There was effective supervision, appraisals were up-to-date and staff were supported with additional continual professional development.
- Staff worked well together in a multidisciplinary environment to meet patients' needs.
- Medical staff were well supported by specialist nurses.
- The service obtained patients health and treatment information from relevant sources before each clinic appointment.
- The service shared patient information with their GP and other relevant agencies to ensure continuity of care for the patient.
- Staff practiced and complied with the requirements of the Mental Health Act (MHA) and Mental Health Act Code of Practice (MCA). The trust also worked effectively in partnership with others to promote the best outcomes for patients in line with MHA.
- Chaparone service was available and we saw this in practice.

Evidence-based care and treatment

Outpatients

- Care and treatment followed appropriate national guidance. The National Institute for Health and Care Excellence (NICE) and the Royal College of Midwifery, and other best practice guidelines, were available to staff via the intranet.
- Each speciality clinic conducted audits to assess compliance with NICE guidelines in relation to their area of clinical practice. For example, the diabetes outpatient clinic used protocols and checklists to ensure patients with gestational diabetes (a type of diabetes, which affects women after 28 weeks of their pregnancy) were treated and monitored in line with NICE guidelines.
- We saw good practice within the colposcopy and hysteroscopy outpatients department. Patients who staff assessed as unable to give consent had their appointments rearranged to ensure a family member or health professional supported them.

Diagnostics and Imaging Services

Outpatients and diagnostic imaging

- Local and national audits complied with NICE and IR(ME)R guidelines across all areas of diagnostic and imaging services.
- The service benchmarked against protocols from Birmingham Children's Hospital when reviewing non-accidental injuries to ensure they followed good practice.
- It is a requirement of the IR(ME)R regulations for audits to be carried out to ensure safe exposure and practice. Staff audited dose reference levels which complied with IR(ME)R regulations and were reviewed monthly.
- Did not attend (DNA) rates were audited. Plans were in place to text patients to reduce the number of DNA's.
- Plain film audit (a radiographmadewithoutuseofacontrastmedium) and new baby radiographs audit was monitored by the RPA each month to limit doses by reducing any risks caused to patients.
- Staff told us auditing of community scanning midwives took place to determine how long it took images to be loaded on the Picture Archiving and Communication System (PACS), in addition to auditing the time it took midwives to write reports.

Pain relief

- Staff accessed appropriate pain relief for patients within outpatients and diagnostics services.
- A doctor assessed and prescribed treatment as appropriate when a patient was in pain.

Patient outcomes

Outpatients

- The number of patients seen as a follow up against the number of new patient's was 1.78 and was lower than the England average from July 2014 to June 2015. This could be indicative of a good performance of the trust being efficient of seeing and treating new patients as opposed to being clogged up with follow up appointments with existing patients.
- The specialist nurse in colposcopy had devised a pathway to help patients stop smoking to reduce cervical cancer. It involved an on-line referral and in one year out of 78 patients, three managed to stop smoking.
- The physiotherapy department monitored outcomes in patient symptoms from referral to after treatment using a questionnaire: 'patient's global impressions' (PGI), this information was not available during the inspection.
- The matron lead from the antenatal clinic informed us they measured key performance indicators (KPI'S) on reducing the waiting times in clinics for patients having their screening, booking and taking bloods. The matron told us it was poor in these areas at 9% 12 months ago and now had improved to 35% following their telephone history booking system (used prior to patient's appointments to reduce waiting times).

Diagnostic and Imaging Services

- Diagnostic clinics were overbooked and often ran over. The central booking office booked radiology appointments and radiology staff had no control of bookings.
- Demand of the service and the capacity of the department did not match. The birth rate had increased however, staffing levels within the department had not increased to accommodate this.
- The diagnostic department reported on 95% of scans and films before the patient left the department.
- Staff sent GP reports by post and plans were underway to change this method to an electronic system.
- Head of Imaging informed us they are involved with research such as scanning and miscarriages, which helps to reduce the number of scans patients receive. The Head of Imaging also informed us they are an Imaging Services Accreditation Scheme (ISAS) assessor.

Competent staff

Outpatients

- Staff across outpatient services was up-to-date with clinical supervisions and appraisals.
- Staff we spoke with informed us they hold the required professional registration and received notice by email when it was due to expire.
- Specialist nurses undertook training such as immediate life support and inoculation injury (an injury caused by an object or instrument, which may cause a puncture or incisional wound in the skin) training.

Diagnostics and Imaging Services

- Staff in diagnostics and imaging services were up-to-date with appraisals and clinical supervisions. Staff were appropriately trained in administering radiation.

- In addition, staff had completed their mandatory training and some were paediatric trained scanners. However, staff felt they were too busy in the department and found it hard to set time aside to attend training courses due to the demands of the service.
- Staff were supported by a (RPA) from a neighbouring NHS trust. There was a service level agreement in place to ensure staff were trained and administering radiation appropriately.

Multidisciplinary working

Outpatients

- There was good MDT working between all the staff within the outpatients department. Doctors, nurses and agency staff worked well together for the benefit of patients.
- For example, consultants from the neighbouring NHS trust worked with Birmingham Women's Hospital to run specialist clinics in outpatients.
- Letters sent out by the outpatient department to patient's GPs provided a summary of the consultation and recommendations, this ensured a multi-disciplinary approach to patient care in a timely way. Staff also provided patients with a copy of this letter.
- The outpatients department had an acute gynaecology clinic and an antenatal clinic, which provided a one-stop clinic involving different disciplines of staff working together. For example nurses working alongside radiographers and consultants. The intention was that patients could come to one appointment and see a range of specialists to minimise further appointments.

Diagnostics and Imaging services

- There was good MDT working between diagnostic services and all outpatients departments.
- Staff attended MDT meetings, minutes supported this and staff felt information sharing between disciplines was consistent and timely.

Seven-day services

Outpatients and Diagnostic Services

- The outpatient clinics ran from Monday to Friday within the core hours of 8am to 5pm. Nursing staff worked until 8pm each evening. An emergency service was available for patients with concerns or problems outside normal clinic hours so they could access support. A phone number was available for patients who were experiencing difficulties. Nurses contacted and invited these patients within 24 hours to attend a clinic the next day.
- The outpatients department offered an obstetrics clinic on Saturdays from 8.30am to 4pm.
- The diagnostic imaging department provided a six-day service from Monday to Friday, 8am to 5pm and provided some reduced hour services such as x-ray and scanning on Saturdays.
- The radiology department provided a range of services, for example, staff were called in from home on a rota basis covering emergency x-rays seven days a week.

Access to information

Outpatients

- The outpatients department had access to patient information to deliver care and treatment.
- The physiotherapy outpatients department had access to an electronic patient administration system, which provided access to tests and results across all departments.

Diagnostic and Imaging Services

- The imaging department used a system that allowed staff to view images and reports from other hospitals, which aided prompt diagnosis and reduced the need for repeat imaging.
- Staff told us there were delays of reports sent to GP's due to internet connections however, an IT system was in place to address this issue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients and Diagnostics Services

- Doctors discussed treatment options with patients during the consultation. Staff obtained written consent in the outpatient clinics.
- Staff completed consent forms across both outpatients and diagnostic services correctly.
- To ensure patients who were unable to give consent received the most appropriate care and treatment staff sought advice and guidance from their line managers or the trusts safeguarding team.
- Staff were aware of the procedures involved in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguarding (DOLS) and were supported by

policies available on the intranet. Staff gave an example of a patient with learning difficulties who did not understand a procedure they were about to receive. Staff stopped the procedure and reported this to the trust Safeguarding Lead. The procedure was explained to the patient in a way they could understand and re-arranged the procedure by making available a chaperone whilst it was undertaken and appropriate consent was obtained following the (MCA).

Are outpatient and diagnostic imaging services caring?

Good

We rated the services 'caring' domain as good because,

- We observed staff were courteous, polite and friendly when responding to patient individual needs.
- Feedback from patients using the FFT questionnaire was positive about the way staff treated them during their care and treatment.
- Staff treated patients with dignity and respect and involved communications positively with their partners.
- Chaperone services were available and used across the outpatients and diagnostics department.
- Staff fully explained patient's treatment and care to them and gave them written information to take home.
- Leaflets were available in other languages to support other ethnic groups.
- Staff supported patients to cope emotionally with their care and treatment during miscarriages and other procedures.

Compassionate care

Outpatients

- We reviewed CQC 'Tell us about your care' comment cards for patients to give their experiences about the care and treatment received from both services. Patients were positive about the services received. Patients informed us "Staff were caring and treated them with dignity and respect."
- We spoke with 26 patients across the outpatients department at the antenatal clinic, physiotherapy, neonatal, and EPAU.
- All the patients we spoke with were happy with the care and treatment they had received. One patient for example attending the physiotherapy department said, "I understand my symptoms more now with this service than any other services I have been to." Patients within the neonatal outpatient clinics said, " the environment is child friendly, I would be happy to recommend it, reception staff treat patients really well."
- Patients at the antenatal clinic were happy with the service stating, "Staff are polite, responsive to their needs and informed us that staff maintained confidentiality at all times."
- Another patient in neonatal outpatients said, "care was respectful and staff had fully involved my partner in all communications."
- Reception staff maintained patient confidentiality at all times within all outpatient services.

Diagnostics and Imaging Services

- We observed staff being friendly and polite in all areas of diagnostic and imaging services.
- Staff were courteous when caring for patients and were seen responding to patient's individual needs. One patient said, "My baby had a very rare condition and the hospital were able to provide specialised care which was sensitive to meet our needs."
- A Lead Radiologist informed us if a patient's wait gets to one to two hours, staff brought up drinks and biscuits for patients.
- A chaperone policy was available to support patients during procedures. For example, staff told us a health care assistant was always in the room when a male sonographer carried out scans.

Understanding and involvement of patients and those close to them

Outpatients

- Staff gave patients good explanations about their care and treatment, in addition to information being readily available on notice boards across all outpatients' areas.
- Some patients in the outpatients department informed us staff did not provide leaflets on post treatment advice, but were told to go onto the website to access it.
- Another patient in neonatal who was at the clinic for her second appointment told us they were very happy with the care and treatment given by staff and procedures were explained to them both in the clinic by doctors and by the nurses and receptionists.

Outpatients and diagnostic imaging

- Staff kept patients informed during and after any treatments, and knew whom to contact if they were worried about their condition when discharged. For example, a patient from EPAU was given an appointment the within 72 hours when their condition deteriorated at home.

Diagnostics and Imaging Services

- Patients had their treatment options explained clearly and they had been involved in decisions regarding their care.
- Information was readily visible for patients on notice boards such as the FFT questionnaire, chaplaincy support, compliment and complaints leaflets.

Emotional support

Outpatients

- Staff provided emotional support to patients who had suffered a miscarriage. For example in the antenatal clinic, there was a quiet room used for parents to discuss sensitive and distressing news. We saw staff used this room to sit down with parents giving them time to talk and ask questions about their bereavement.
- Staff also showed us leaflets of bereavement, which they talked through with patients to seek support and advice.

Diagnostics and Imaging Services

- Patients told us staff throughout the diagnostics and imaging services provided emotional support. One patient informed us they were nervous before scans however, staff reassured the patient and put them at ease and the scan went ahead.
- Patients we spoke to informed us staff introduced themselves before scans, chatted and laughed with patients and had an obvious good rapport.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated the services responsive domain as 'requires improvement' because,

- There were no systems to monitor the waiting times across the clinics.
- There were no systems to alert staff of patients who had learning disabilities.
- There was no clearly defined waiting area for each different procedure during their antenatal clinic visit.
- There was a poor pathway within the antenatal clinic. It was disorganised with no clear plan for the patients in terms of the order in which patients were having different procedures such as blood tests, scans and seeing a doctor.
- Patients reported long waiting times up to five hours when attending the antenatal clinic for multiple appointments.
- Due to increasing numbers of staff seeing women at the trust, the model of care within the antenatal clinic had not changed to meet the needs of patients leading to long waits in the clinic and scanning areas.
- Staff informed us they were always running over and working until late to see patients due to staff shortages. Patients waited up to two hours in the radiology department for their appointments.

However, we also saw,

- Information boards at all entrances and in lifts identified locations of all areas of outpatients and diagnostic departments.
- The service was meeting their National indicators for referral to treatment times.

Service planning and delivery to meet the needs of local people

Outpatients

- The trust provided a range of specialist gynaecology and maternity clinics at Birmingham Women's Hospital in response to local needs, which included diabetes, seizure and teenage pregnancy clinics.
- Within the EPAU there was a hyperemesis (severe or prolonged vomiting) clinic which responded to pregnant women by rehydrating them within six hours of their admission to the hospital and prevented an admission.
- We also observed 'one stop' clinics to provide the care and treatment necessary in as few appointments as possible in the acute gynaecology and the antenatal clinics.

Outpatients and diagnostic imaging

- We saw a strategy for 'better patient care for patients. In the draft stage' which involved making it easier for working parents to attend appointments by having flexible clinic times between 9am and 12pm and 1.30pm to 4.30pm.
- There were information boards at all entrances and in all lifts identifying correct locations of all areas of the outpatients and diagnostic departments.
- Staff from the neonatal baby clinic told us there was no system of alerting staff for patients with learning disabilities on the computer system. However, staff gave appointments to patients at the end of the clinic to allow more time for their appointment.
- A number of patients we spoke to said there were always problems parking in the small car park by the entrance. A patient told us: "It is difficult to park and when appointments take a long time, the parking charges also add up."
- The antenatal clinic operating system was disorganised for patients whilst they were waiting for different procedures of treatment and patients confirmed this.

Diagnostics and Imaging Services

- To respond to emergency scans the radiology department provided an overnight 24 hours on-call service. However, staff were not happy having an on-call system when they were at home. Staff informed us the trust was not changing this due to staff shortages.
- Staff told us appointments could take up to two hours. Staff worked until 6pm to see patients as clinics often ran over which resulted in staff working longer than their planned shift to conduct scan procedures in order to catch up.

Access and flow

Outpatients

- The service referred patients who missed their appointments back to their GP
- Referral to treatment time for non-admitted pathways within 18 weeks (January 2015 to December 2015) was better than the England average for all 12 months – ranging from 95.2% to 97.5% compared to the England average performance of 92.7% to 95.4%. December 2015 saw the trust at 95.7% compared to the England average of 93.1%.
- Referral to treatment time for incomplete pathways within 18 weeks (January 2015 to December 2015) at the trust was consistently above the 92% standard. This was also better than the England average for all 12 months – ranging from 96.1% to 97.7% compared to the England average performance of 92.1% to 93.3%. December 2015 saw the trust at 96.2% compared to the England average of 91.6%.
- From January 2015 to December 2015 the percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was better than the England average, with 100% of patients in all quarters waiting less than 31 days, compared to the England average, which ranged from 97.5% to 97.8%.
- Between January 2015 to December 2015 the percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average for all quarters aside from one (Quarter 3 14/15), ranging from 83% to 100%, compared to the England average of 82% - 84%.
- From July 2014 to July 2015, the 'did not attend' (DNA) rate was in line with the England average.
- There was no system to monitor waiting times across all areas of outpatient's services.
- In the antenatal clinic, we observed there were approximate waiting times displayed on white boards for the midwives for patients to have blood tests. However, there were no waiting times displayed for each doctor. We saw one patient who arrived at 9.30am was still waiting to see a doctor at 12pm.
- We spoke to a couple in the antenatal clinic who complained about waiting for more than five hours on their last visit to have their blood tests, scan and doctor's appointment. They waited on the day of our inspection for the triage appointment for three hours and then waited a further two hours to see a doctor.
- One patient explained they had a blood test carried out in the morning and were told to return for a scan in the afternoon. .
- The service sent out patient's letters to warn them in advance of a two hour wait. When this increased to four hours, the service changed the time on the letter to four hours. This did not improve access and flow for patients. We saw this as an unhelpful action by the service, which did not tackle the root cause of the problem.
- In the antenatal clinic, 16 patients had been booked in due to another clinic that staff had cancelled. The department however responded quickly and minimised the wait by arranging for another consultant to take half the list.

Outpatients and diagnostic imaging

Diagnostics and Imaging Services

- The diagnostic imaging waiting times were consistently lower than the England average for all months between January 2014 and December 2015 (except November 2014 at 0.2%) having 0% of patients waiting more than six weeks compared to the England average which ranged between 1.2 to 2.4%.
- Long waiting times for scans was the main cause of delays in the antenatal clinics. In some cases waited more than 5 hours to be seen.

Meeting people's individual needs

Outpatients

- All areas of outpatients we inspected had visible notice boards with well laid out useful information such as the Patient Advice and Liaison Service (PALS), bereavement support, interpreting services, listening and responding to patients feedback and hand washing information.
- The service managed vulnerable service users by seeing them at the start of the clinic.
- There was an alert system on the electronic appointment system, which alerted staff if a patient required a translator when booking their appointments. This enabled translators to be booked in advance for patient appointments.
- A telephone translation service was also available for staff to aid communication with patients whose first language was not English.
- A professional such as a carer, usually supported patients with learning disabilities and mental health issues, and a chaperone service was available to patients when required.
- We saw vending machines for patients, which contained snacks including healthier options in the antenatal clinic.
- We also saw a new baby changing facility, paid for by a local charity.
- There was a transport service made available to patients with mobility issues across all departments in outpatient services.
- Within the colposcopy department, a clinic room had a ceiling picture for patients to look at whilst having their procedure, which helped to reduce patient's anxieties.
- We spoke to a receptionist who informed us that they used a buzzer system for patients so they can leave the department and have refreshments whilst waiting for their appointment.
- The departments across all outpatient services had appropriate environments and were patient centred by having sufficient comfortable seating, toilets, magazines, drinks and a separate play area for children.
- There was also a quiet room within the early pregnancy assessment unit, which staff used to speak to patients when dealing with sensitive outcomes such as miscarriages.
- In the outpatients department there was a television, free Wi-Fi and a separate play area for children. Refreshments were also available throughout the departments.
- There were chaperone posters displayed in the general outpatients waiting area. One patient informed us a staff member had offered a chaperone during their treatment and care, and the service had always been available.

Diagnostics and Imaging Services

- The general manager of radiology told us staff used interpreters and were booked for patient scans via a receptionist. They also used an interpreter service and language line. They did not use family members to translate but used their own staff that was on the translator list within the trust. We saw the use of three types of interpreter services worked well in practice.
- Patients living with dementia and patients with a learning disability were seen at the start of the clinic list as a priority. Staff were trained in (DoLs) and safeguarding and knew the processes regarding who to contact if they needed advice to support vulnerable patients.
- Patients who were allergic to latex gloves worn by staff were risk assessed and a latex allergy alarm was in place on the computer system to warn other staff members.

Learning from complaints and concerns

Outpatients

- There were 21 complaints from the outpatients and diagnostics department between January to December 2015, 20 of which related to the outpatients department. The main themes of the complaints involved all aspects of clinical treatment particularly around communication and information, attitudes of staff, appointment delays and cancellations.

Outpatients and diagnostic imaging

- Staff displayed and we saw posters on notice boards across all outpatient services explaining how to make a complaint.
- Staff discussed complaints at monthly governance meetings and was shared at their local team meetings. We saw minutes of these meetings and staff confirmed lessons learned from complaints were fed back to them via emails and a newsletter entitled 'Risky Businesses.'
- Staff across all outpatient services was able to explain the complaints process and knew when to escalate the concern to senior managers.
- The colposcopy department had complaints from two patients who did not receive the treatment they thought they should have. Staff resolved this problem by inviting the patients to come into the clinic to discuss these issues and found the patients were not clear about the procedures. Staff discussed learning from this complaint, which included better communication between staff and patients.

Diagnostic and Imaging Services

- There was one complaint in the diagnostics department, which was within the antenatal scan area. A patient who suffered a stillbirth in 2014 saw the same sonographer, for a later pregnancy, who she found uncompassionate, heavy handed and had no empathy. The trust apologised to this patient for the lack of compassion and empathy. We saw all aspects of this complaint was managed swiftly and sensitively.
- The head of imaging informed us most complaints in diagnostics and imaging services were regarding waiting times and not communicating well with patients. We also confirmed this when we looked at the complaints.
- Staff discussed these complaints at monthly staff meetings where memos was sent to all staff, which was open and transparent about complaints and concerns within the trust.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated the services well led domain as 'requires improvement' because,

- Staff told us and we observed the excessive waiting times in the antenatal clinic were not on the risk register and risks that were identified had no action plan or timeframe for review.
- The trust was aware of the poor pathway in the antenatal model of care and had commenced evaluating a pathway. However, there was no definitive timescales for completion within their action plan.
- Staff highlighted other risks, which were not on their risk register, for example, environmental constraints of 'space' to accommodate the increasing number of patients. The service was not monitoring or reviewing all risks.
- The appointment system was not fit for purpose as 20 week scans took 20 minutes per scan rather than 30 minutes per scan recommended by the Fetal Anomaly Screening Programme (FASP) guidelines.

However, we also saw;

- There was a clear vision within outpatients and diagnostic imaging services departments. Staff in all areas were able to describe the vision and strategy for each directorate.
- All staff understood the hospitals strategic plan and was all positive about the acquisition by Birmingham Children's Hospital.
- There was clear leadership in both outpatients and diagnostic imaging services where staff felt supported by their managers who were visible in the departments and provided an open door policy.
- There were examples of innovative practice in both outpatients and diagnostic imaging services. Staff were proud of the hyperemesis unit, acute 'one stop' gynaecology clinic, and e-learning package in conjunction with the Liverpool Women's Hospital to measure safe use of insulin and other initiatives to 'stop smoking' to reduce cervical cancer.
- The radiology team were positive of the new structure going forward led by a new management team who had a clear strategy to run the service.
- The radiology team had implemented proposals to increase the salary of sonographers to address problems of staff shortages.

Vision and strategy for this service

Outpatients

Outpatients and diagnostic imaging

- Staff were able to describe a clear vision within the outpatients department. For example, within the neonatal outpatient clinic, senior staff nurse informed us that a fund from a charity to build an outside play area for children was in progress.
- Day assessment unit staff understood the vision and values of the hospital and told us about a strategic objective for expanding the hours of the day assessment unit to 8am to 8pm to see more maternity patients.
- The managers we spoke to were aware of the hospital's vision and values within the outpatients departments. For example, a Lead Matron informed us they had plans to increase cardiac clinics by having 60 more appointments for patients.
- The Head of Nursing also told us about the vision for the gynaecology outpatients department. The document was entitled 'Gynaecology outpatient department philosophy of care.' They also explained the vision of 'What does good gynaecology look like for patients.' This included better collaborative working with other units, working on rotas differently by providing 24 hours a day cover and maintaining the specialist nature of the service.

Diagnostics and Imaging Services

- There was a clear vision and strategy for the radiology service.
- The Radiology strategy for 2016/17 model of care described a change to the existing model of care for antenatal department of seeing more patients and expanding the hours to see more patients.
- The manager also informed us about a strategy to remove the cap on the number of patients seen at their clinics. This could not be changed due to space constraints of their current building however, the merger with Birmingham Children's Hospital would provide more opportunities.
- Plans were in place to train more midwives in sonography scanning by allowing more low risk patients to be treated in the community so that they can focus on more high risk patients at the hospital.
- The Head of Imaging told us they were positive about the merger with Birmingham Children's Hospital, which will help in the expansion of the building, which currently has limited space to see patients.

Governance, risk management and quality measurement

.**Outpatients**

- There were 24 risks on the risk register for outpatients and diagnostics, four of which related to the radiology department.
- We spoke to senior staff who were unsure whether the long waiting times were on the risk register. We confirmed this was not on the risk register when we reviewed it.
- The trust was aware of the poor pathway in the antenatal model of care and had commenced evaluating the pathway. However, there was no definitive timescales for completion within their action plan when reviewing the antenatal clinic and scan pathway review paper.
- The matrons told us each directorate reported risks separately into the risk register, however all incidents were discussed at the POC (patient outcome committee) meetings where shared learning took place from these incidents.
- In addition, we saw monthly governance meetings took place and discussed the risk register, complaints, incidents, lessons learned, audits and actions to take in the future. We saw minutes of these meetings.
- The service introduced a protocol to ensure all staff was wearing gloves when delivering care and treatment to patients following a complaint by a GP. The GP raised a concern after they attended for a blood test and the MCA (Midwife Care Assistant) was not wearing gloves. Several types of gloves were trialled and staff purchased the most suitable one for future use.

Diagnostic and Imaging Services

- There was a clear governance structure in radiology. However, staff highlighted risks, which were not on their risk register. For example, environmental constraints of 'space' to accommodate the increasing number of patients. Therefore, we were not assured staff regularly monitored or reviewed risks.
- Two other risks relating to radiology were on the risk register, which were staff shortages and the on call 24 hour system for radiographers due to not having enough staff to cover it. Staff were not clear whether there were definitive timescales for risks to be completed and whether it was reviewed or not.
- However, we did see a clear ownership for ensuring the department worked within best practice professional

guidelines and IR(ME)R regulations. Staff informed us they had two Radiation Protection Supervisor (RPS) and a Radiation Protection Adviser (RPA) located at the hospital site who advised them regularly.

Leadership of service

Outpatients

- Staff in all areas of the outpatients department told us they felt well supported by their managers who were passionate about patient care.
- A matron and the Head of Nursing managed the service and staff told us they were supportive and approachable.
- The outpatient's matron felt well supported and valued by the Executive Team. They reported good two-way communication between the department and the board and felt comfortable to raise concerns.
- Staff were well supported by senior managers who encouraged them to attend role specific training for continuous professional development.
- A staff member from the day assessment unit informed us the Head of Midwifery supported their career progression.

Diagnostics and Imaging Services

- Staff were happy and proud to work in the department and felt supported by the management team.
- Staff also told us the Manager of Radiology was always visible in the department and was approachable by having an open door policy.
- The Radiology Manager told us new sonographers who joined the trust had a sonography buddy to support them with their induction.
- The appointment system was not fit for purpose as 20 week scans took 20 minutes per scan rather than 30 minutes per scan recommended by the Fetal Anomaly Screening Programme (FASP) guidelines.

Culture within the service

Outpatients

- Staff reported a positive, open culture where they were encouraged to report incidents. Staff were passionate, committed and proud of their patient care work.
- Staff supported each other and there was good team working within the department.
- One senior band six nurse said: "Team morale is really good, support from each other, staff help each other out if there were any negative outcomes with patients"

Diagnostics and Imaging Services

- Staff were positive about future plans of the service being driven by the new Radiology Lead.
- Staff in the department told us in the past they had inherited current problems from previous leadership. Staff now felt it was better for the department due to better finances and being open and transparent about historical failures.
- We observed good evidence of teamwork and patient care where staff said, "nice environment to work for in the radiology department," "good place to work" and "put yourself in the patient's shoes."
- However, staff were unhappy about being called in from home whilst being on the on-call duty rota, they felt the system in place was not fairly managed and staff had little say in their rota duties.

Public and Staff engagement

Outpatients

- We observed the FFT feedback box in the EPAU reception. The comments we observed were all positive. Staff were described as 'helpful, friendly, reassuring, informative and provided the best service.'
- Staff were given feedback from the FFT during weekly staff meetings, and the information was displayed on the noticeboard addressing the problems raised by patients and what measures had been put in place to address them.
- Staff told us they felt listened to and supported by senior managers when making suggestions for improvements and changes for the service.

Diagnostics and Imaging Services

- We observed in the radiology department FFT leaflets were available in the waiting areas.
- The radiology department was aware of FFT complaints about waiting times and the clinic environment and what staff were putting in place to address this such as recruiting more staff.
- The trust consistently scored better than the England average in the friends and family test with a recommend rate of 96 - 98% for all months (August 2015 - February 2016) compared to the England average of 92%.

- Staff were involved in the planning and delivery of the services. For example, the manager had plans agreed relating to the recruitment and retention of sonographers.

Innovation, improvement and sustainability

Outpatients

- Staff were positive and proud of innovative practice that had been implemented within the outpatients department, for example, an e-learning package in conjunction with Liverpool Women's Hospital had been developed on the safe use of insulin for patients.
- The physiotherapy staff won a recognition award for being the best department in the trust in 2014.
- The home birth team set out national guidelines for other trusts to measure against.
- The gynaecology department provided fast rehydration to patients seen in the hyperemesis clinic, which reduced re-admissions and overnight stays.

Diagnostic and Imaging Service

- Staff told us about an initiative to train community midwives in sonography growth scans, which will help to increase the number of staff qualified to do these scans.
- Sonographers were trained in reporting plain film audits, which were useful in maximising any spare capacity in the department.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The symptom specific triage assessment card within inpatient maternity services delivered consistency and clear targets for the triage process.
- Video books were available for women across acute and community services who did not speak or read English.
- The trust was awarded a (SDIP) grant by local commissioners to pilot a three year project to set up a Homebirth Service, one of its kind in the region.
- Funding was sought from the Local Education Training Council (LETC) to fund a two year foundation degree to enable the maternity assistants to acquire the necessary competencies to assist the midwife at home-births.
- Staff within the neonatal services introduced the routine use of pulse oximetry for all babies within 24 hours of birth or prior to discharge. This has been identified as significant in the early detection of critical congenital heart defects prior to the deterioration of the baby. The business case and rationale for testing has been shared nationally and around 20% of hospitals now routinely perform this test.
- Gynaecology services had been successful in becoming an accredited British gynaecology endoscopy (BSGE) centre for complex endometriosis. This is a regional specialist service whereby women with complex endometriosis are referred and includes medical, pain related and surgical management.

Areas for improvement

Action the hospital MUST take to improve

Action the trust MUST take to improve;

- Healthy Start vitamins must be stored securely in all community maternity team offices.
- Medicines are prescribed and stored in line with the trust policy, particularly intravenous fluids.
- All community midwives must attend safeguarding supervision in line with Department of Health requirements (Working Together to Safeguard Children, 2015).
- Improve the application of infection prevention and control procedures in relation to the use of personal protective clothing and equipment and hand hygiene.
- Properly maintain all equipment and medical devices.
- Provide secure storage for patient records across all clinical areas.
- Ensure the project to develop a second emergency theatre team is progressed in a timely manner.
- The trust must ensure all HSA1 certificates for termination of pregnancy are fully completed by the registered medical practitioners signing them.
- Identify, monitor and mitigate all risks relating to developing the complex abortion service pathway. In particular in respect of processes required and the impact on staff and patients of distressing elements of late gestation termination.
- Provide training to ward staff caring for complex abortion services patients in the appropriate procedures for responding to late gestation termination of pregnancy where the foetus may be indicating signs of life.
- Ensure team work between the complex abortion care service, ward teams and bereavement team and wider medical teams are strengthened to mitigate risks involved in late gestation termination of pregnancy.
- Take steps to ensure multi-disciplinary team work is improved where clinicians from other trusts are contributing the care of patients.
- Clarify the method clinician's should use to establish consent to termination of pregnancy from adult patients with learning disabilities.

Outstanding practice and areas for improvement

- Ensure that the data collected for the Neonatal Audit Programme (NNAP) reflects the care given within the unit.
- Ensure staff receive mental capacity training in line with trust guidance.
- Implement a system to assess, monitor and improve the waiting times across clinics in the outpatients and diagnostic departments.
- Mitigate the risks relating to the health, safety and welfare of service users by regularly reviewing the risk register and include a timescale in completing any risks identified.
- Reduce the waiting times in diagnostics department
- Ensure old diaries used by community midwives are securely stored.

Action the hospital SHOULD take to improve

Actions the trust SHOULD take to improve;

- Review community midwives' caseloads to ensure equitable distribution of numbers and complexity pending review of staffing planned for June 2016.
- Review how patients are informed about and supported to clearly understand the process and all potential clinical elements of late gestation termination of pregnancy.
- Develop and put in place agreed after care pathways for ward staff to follow to best support patients. These should address the needs of patients where they may differ in respect of the decision to terminate their pregnancy.
  - Review the procedures for pre-operative fasting to ensure food and fluids are withdrawn for the minimum length of time to ensure the safety of patients and the maintenance of hydration.
  - Ensure where best interest decisions are made on behalf of a patient that reasons for the decision and other options considered, are clearly recorded.
  - Review the application of its policy for the use of interpreters to ensure all patients who require an interpreter are offered an independent interpreter.
  - Ensure there are processes in place to ensure learning is shared between different parts of the service and there is improved communication across services to enable the development of best practice.
  - Take steps to improve the accessibility and reliability of the electronic care planning system in place in gynaecology.
  - Consider the perception that gynaecology is not dealt with equitably and issues prioritised in the same way as for other services and take steps to ensure equity.
- MEWS charts are completed appropriately.
- Patients undergoing induction of labour are supported to continue the induction process within a satisfactory timeframe.
- On-site consultant hours reflect the recommendations by the RCOG in relation to number of births.
- Use the capacity data captured to influence staffing levels and business plans.
- Consider it provides the persons with the information they would reasonably need by giving patients leaflets about their post treatment, rather than being directed to go onto the website.
- Consider it has a consistent system across all departments to flag up any learning disability patients.

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
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 Good Governance Regulation 17 (1) (2) (a) (b): The trust had not identified, monitored and mitigated some risks relating to developing the complex abortion service pathway. In particular in respect of processes required, the need to provide training to staff because of the impact on staff and patients of foetus showing signs of life in late gestation medical terminations. There was a systemic failure by the registered medical practitioners (RMP) to clearly indicate on some HSA 1 certificates if the patient had been 'seen/treated' by either of the two RMPs who signed the certificate. This was because a section of the form had not been properly completed. This meant the trust had not captured through audit the risk to breach of its condition of registration of ToP services under the Health and Social Care Act.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Safe care and treatment Regulation 12 (2) (e), (g), (h) which states Medicines including intravenous fluids were not stored securely

This section is primarily information for the provider

Requirement notices

Staff were not consistently adhering to infection prevention and control procedures in relation to the use of personal protective clothing and equipment and hand hygiene.

Equipment such as beds and infusion pumps had not been subject to regular servicing and electrical safety checks.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17 Good Governance** Regulation 17 (1) (2) (a) (b) The trust had not identified, monitored and mitigated some risks relating to the long waiting times across clinics in the outpatients and diagnostics department. In particular, in respect of the antenatal clinic the long waiting times was not on the risk register by not being regularly reviewed, and did not include a timescale in completing any risks identified.

Regulated activity	Regulation
Termination of pregnancies	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **11 Need for Consent** Regulation 11 (4) The service had no established pathway in place for addressing consent to treatment for women with a learning disability.