Birmingham Women's and Children's NHS Foundation Trust

Birmingham Women's Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Birmingham Women's Hospital

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location. From page 3 the ratings and information relate to maternity services based at Birmingham Women's Hospital.

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

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

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

Birmingham Women's and Children's NHS Foundation Trust provides maternity services for the population of Birmingham and the surrounding areas. The fetal medicine centre receives regional and national referrals. The maternity department comprises of delivery suite, triage, postnatal and antenatal wards, day assessment unit, midwife and consultant led clinics, scanning services, a bereavement suite, as well as a maternity led unit birthing centre.

We did not review the rating of the location therefore our rating of this hospital stayed the same

This hospital is rated Good.

How we carried out the inspection

We spoke with 32 staff including senior leaders, matrons, shift leads, midwives, obstetric staff, specialist midwives, receptionists, cleaning contractors, clinical governance leads and safety champions to better understand what it was like working for the service. We interviewed leaders to gain insight into the trust's leadership model and the governance of the service. We reviewed 8 sets of maternity and 17 medicine records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recent reported incidents as well as audits and audit actions.

We ran a poster campaign during out inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 2 feedback forms from women. We analysed the results to identify themes and trends.

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

Maternity

Good ➔➔

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

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

However:

- Recruitment and retention had been a challenge and there were not always as many staff on duty as needed or to allow for mandatory training updates.
- Not all mandatory training was up to date such as for safeguarding.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

The majority of Nursing and midwifery staff and medical staff received and kept up to date with their mandatory training. However, there were some departments within the maternity department who need to improve their compliance in some modules of the mandatory training in order to meet the trust target of 90%.

For example, 15 departments/wards had met or were above the 90% target regarding equality and diversity training. However, 7 departments/wards were below this target with the maternity diabetes team having 67% compliance (1 out of 3 had completed the training). There were 8 departments/wards who had 100% compliance with training equality and diversity training.

Neonatal Life Support (NLS) is mandated for Band 7 and Homebirth Team midwifes, there was a 98% compliance. However, Immediate Life Support (ILS) is also mandated for the band 7 midwifes and Delivery Suite coordinators. Compliance rate for ILS was only 53%. Trust leaders were aware and were looking at making improvements.

Maternity

The birthing centre had birthing rooms with pools. All staff who worked in the birthing centre had received up to date training in how to support a woman or birthing person in a pool evacuation emergency.

The service made sure that staff received multi-professional simulated obstetric emergency training with several dates available for staff to complete this training.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and fetal monitoring. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Managers have access to and monitor mandatory training compliance, and automatically re book staff on mandatory training when needed. Practice development midwifes told us that they were building training back up following the COVID-19 pandemic and when training falls below the 90% target they act accordingly to prompt staff to receive the training they need.

The trust had an education strategy and training needs analysis which they were working towards achieving.

Newly qualified band 5 staff working in their preceptorship had a programme of training to complete to pass their preceptorship and were supported by a preceptorship midwife. Data we received showed this was being monitored and actioned.

During the inspection we spoke with staff about their experience of working at the service. Some staff said that they were having to complete mandatory training in their own time as they did not have time to do this whilst on shift. Leaders advised us the service was taking part in a national piolet of the “Core Competency Framework 2” which involved assessment of the additional uplift required to enable staff to have enough allocated time to complete mandatory training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The service had a corporate safeguarding team covering neonates, gynaecology as well as the maternity department. This comprehensive team consisted of 9 staff, including staff trained specifically to support with perinatal mental health, substance misuse, female genital mutilation (FGM) domestic violence, teenage pregnancy and learning difficulties. The safeguarding team trained staff to recognise and be able to report concerns they were available to support staff with all safeguarding matters including supervision.

Staff knew how to identify adults and children at risk of or suffering significant harm, and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system.

We reviewed the notes of 8 patients who had all been asked if there were any issues regarding domestic abuse. Staff did not ask this question if it was deemed inappropriate to do so, instead they would record and prompt for the question to be asked at a later date. Midwifes routinely asked about women and birthing peoples mental health and would discuss referrals for support if needed.

Where safeguarding concerns were identified women and birthing people had birth plans which were reviewed by the safeguarding team.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Midwives and obstetric staff were trained in both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Compliance rates varied between staff groups from only 59% for senior medical staff to 100% for the breast feeding team. Due to several departments being below the trust target for safeguarding training the safeguarding team was providing focused support to the departments most affected to ensure compliance improves, as well as increasing the presence of the safeguarding team in clinical areas.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

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

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

Staff were up to date with infection control training with all midwifery staff being 100% compliant with the training.

The premises were all visibly clean and cleaning records were up to date. We saw Housekeepers going about their duties throughout the day. There were suitable furnishings which were clean. Staff used green I am clean stickers to show that equipment and furnishings had been cleaned after use. Environmental audits showed staff knew what to look for when assessing the environment. Photos were taken by staff as evidence when issues were found, and reports made to estates for repairs to be made.

The flooring and decoration in clinical areas allowed for effective cleaning and was well maintained.

Ward managers and the clean team audited the environment every month contacting estates with any concerns that needed actioning, including photographic evidence for the estates team.

Maternity

Leaders completed infection prevention and control (IPC) and hand hygiene audits. We reviewed data from the last 12 months which showed hand hygiene audits were completed in all maternity areas, with targets of over 95 % compliance being achieved. However, in February 2023 the delivery suite only achieved 94% and no data was submitted by the antenatal clinic.

Environment and equipment

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

The senior management team looked at their available space and adapted to the needs of the service whenever the service needs had changed. This was especially evident during and after the COVID-19 pandemic when several changes had been made to adapt the environment.

There is a dedicated reception and waiting area for the maternity department located with access to triage, delivery suite and birthing centre. The reception area was staffed 24 hours a day. The waiting area is locked out of hours and manned by security personal. The seating area was clean and comfortable for women and birthing people.

Triage is open 24 hours a day with a dedicated phone line that is manned from 10am to 10pm. There were assessment rooms as well as rooms dedicated for women that needed to be seen urgently by a doctor. Triage was for women from 17 weeks of pregnancy up to 6 weeks postnatal who were experiencing any problems related to pregnancy or following birth. Women also attended for early labour assessments. Fetal assessments were offered for reduced fetal movements. Triage was situated next to labour ward so women could be transferred immediately if needed.

Delivery suite consisted of 3 high dependency beds, 2 theatres, 1 room that could be adapted if a 3rd theatre was needed, 15 delivery rooms and a 5 bedded induction bay. The induction bay capacity had been reduced during the COVID-19 pandemic to comply with infection control recommendations. This gave women and birthing people the space they needed allowing partners to stay with women and birthing people overnight. These arrangements had been maintained as there was an improvement in patient experience. The delivery suite had received improvements in the last 18 months to the theatre’s, flooring and ventilation system. There were 2 bereavement rooms in the delivery suite to support when needed. These rooms were sound proofed. There were plans for a specialist bereavement suite in an adjacent building to support women and birthing people.

The day assessment centre had been moved during COVID-19 to allow more space for triage. Staff reported this had benefited women and birthing people using both triage and the day assessment centre.

All areas of the maternity department were fully secure. Security staff had recently been appointed due to senior leaders listening to staff concerns. There was an effective baby tagging system in place which alerted staff if a baby had been moved to an area they should not be in.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily.

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

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

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

Assessing and responding to risk

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

We reviewed 8 maternity care records. In each record risk factors had been defined and identified at the booking appointment and risk assessments were completed at each maternity contact. This enabled women to be allocated to the correct pathway to ensure the correct team were involved in leading and planning their care.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. Staff completed and recorded MEOWS observations electronically. Management audited compliance with their MEOWS policy. Results showed observations were completed, concerns were escalated according to risk, and women were reviewed within expected time frames.

Staff used an evidence-based, standardised risk assessment tool for maternity triage. Due to the effectiveness of the assessment tool, space and staffing of the triage, women were seen within 15 minutes of arriving. Women and birthing people were seen by an experienced midwife who rated them a colour dependent on their clinical need. The colours used were red, orange, yellow and green. If a woman was classed as red, they would automatically go to the delivery suite. Women who had been rated yellow or green would be asked to return to the waiting room. Women rated orange would transfer to an assessment room known as the “hot room” to be seen by a doctor. If there was more than 1 woman rated orange staff were able to allocate another room to be a hot room, within the triage area. This process had ensured ongoing assessment took place within the assessment tool time frames. Additionally, staff used an electronic system to identify what colour women had been allocated and where those women were. This system meant that staff were able to monitor safely a women’s progress reviewing regularly, including after any incident.

An audit of maternity triage waiting times had been undertaken for all attendees between 1 October 2022 and 31 December 2022. The audit demonstrated 76% compliance of being seen within 15-minute time of arrival for October 2022, falling to 72% in November 2022 and 66% in December 2022. The audit identified that the time of day had the biggest impact on waiting times for ongoing assessment, with the shortest waiting times during the 'normal' working day and peaking at the extremities of late night and early hours. The service has a dedicated triage quality improvement (QI) group involving members of the multi-professional team. All triage audit findings are fed into an overarching project action plan and utilised as measures of progress and the development of further change ideas using QI methodology.

During the inspection we raised concerns regarding women and birthing people giving birth outside of delivery suite of the birthing centre. There is a risk that women who give birth in non- intended birthing areas may not receive the same safe care and treatment. We were advised that there is a daily report shared with the maternity leadership team identifying the number of births and the location. From this report leaders review information leading to the location of the birth. Prior to the inspection the service had reviewed 6 months of data and identified recommendations and actions to improve the quality of care. These audits contributed to the ongoing quality improvement projects in induction of labour and in triage.

Maternity

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communications and teamwork. The service audited WHO checklists. Data from October, November and December 2022 showed the service was 100% compliant with the tool. However, on 2 occasions a midwife had left the theatre before signing out and was called back to do so.

Staff knew about and dealt with any specific risk issues. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited quarterly how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The October to December 2022 audit showed an increase of compliance and documented fresh eyes from 66% at the last audit to 78 % compliance. Each quarterly audit had an action plan that was shared with staff.

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

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

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

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

The service provided transitional care for babies who required additional care. Birmingham Women's and Children's NHS trust have specialised facilities for babies who require additional care. Babies are often transferred from nearby maternity facilities when needing additional support.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed time frames and national targets.

Women who chose to give birth outside of guidelines were supported. These women were offered an appointment with the consultant midwife and/or an appointment with a consultant obstetrician. The consultant midwife discussed the woman's decision, and they agreed a birth plan together. The aim was to support women's choice and to ensure the birth was as safe as possible. The consultant midwife and on-call team were available to support midwives caring for women outside of guidance. Midwives told us the teams worked together well to support informed choice. Midwives also felt well informed and well supported in these situations.

Maternity

Midwifery Staffing

The service did not always have enough maternity staff. Staff had the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In December 2022 there were 18 red flag incidents. Maternity staffing papers which are reported quarterly to the quality committee state midwifery staffing, activity and acuity is collected 4 hourly, daily by the shift leader. All red flags are reviewed alongside incidents.

The service did not always have enough nursing and midwifery staff. Managers would review staffing twice daily at staffing safety huddles. Senior midwives such as specialist midwifes provided care to support the flow and capacity of the department Managers moved staff according to the number of women and birthing people in clinical areas, redeploying staff to areas they were familiar with and were given support from the clinical education team when needed. However, despite this planning and support, staff told us they were deployed at short notice and expected to work in areas unfamiliar to them.

Recruitment and retention had been challenging since the start of the COVID-19 pandemic. However, several projects had been undertaken to improve staffing levels. There were international educated midwives within the service who were undergoing preparation for the Objective Structured Clinical Examination (OSCE) as part of their employment, with a further cohort waiting to join the programme later in the year. Trust employed bank staff were paid at an enhanced rate. This was effective in covering vacant shifts. Registered nurses were employed to work alongside the enhanced care midwives, providing high dependency level care with competency assessment documents in place to support and ensure safe care provision and support to reach the required standard where required. Additionally, specialist midwives and ward managers were rostered to support essential shifts.

The trust had appointed a retention midwife as part of their workforce strategy. Part of their role was looking at ways to support staff to stay working in the trust. Developing plans for each individual aimed at addressing the reasons they are considering leaving.

A staff recognition scheme had set up to reward nominated staff. The retention midwife and leaders had reviewed responses from a staff retention survey and acted on the findings, ensuring there were clinical development opportunities and flexibility. We were told the trust had retained 18 staff who were planning to leave but did not. Recruitment events had been successful in appointing newly qualified and student midwives. A dedicated intranet site promotes opportunities for internal transfers.

Although staff told us that the service was short staffed, they also said they recognised this had been getting better.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. Practice development lead and preceptorship midwife explained that they would review rotas to

see where band 5 preceptorship midwifes were working and would offer support. If a preceptorship midwife expressed they needed support in a certain area, such as suturing or cannulas, they would support with this as and when needed rather than waiting to put them on a training session. The trust also had an advanced midwifery practice development pathway for midwifes to further their careers within the trust.

The trust has supported sponsorship of 8 maternity support worker team members for the level 4/5 Foundation degree which started in September 2022.

Medical staffing

The service did not always have enough medical staff. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. Medical staff had the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff and used locums to backfill gaps in cover. This included 3 consultant locums which they used regularly. Birmingham Women's Hospital required 168 hours of senior medical cover per week. However, the cover was 116 hours with least cover provided at the weekend. The trust was in the process of looking at job plans, reviewing rotas and recruiting to cover the locum posts.

The service had a night-time handover and a consultant ward round 7 days a week. When there was no onsite consultant cover after the night-time ward round the service mitigated the risk by providing overnight on- call cover of 30 minutes or less to the site.

The service had struggled with fewer trainees, which is a national issue as the workforce is less due to obstetrics being a consultant-based service. Staff grade doctors are not always available to fill the spaces.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

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

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used an electronic records system. We reviewed 8 records and found records were clear and complete.

When women and birthing people transferred to a new team there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

The service had a digital midwife who was able to support staff when needed with any issues relating to the electronic records system. They were also able to support the leadership and governance team if running reports and audits on the data stored in the electronic system.

Women and birthing people accessed their own electronic records using an app. If a woman or birthing person did not have access to an electronic devise to access their records, they would be printed off for them. All local maternity hospitals were using the same electronic system which meant if women and birthing people were to need care in a different local hospital the staff would still be able to access their records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, some systems were limited in the recording of staff medicine management competency.

Midwives who are in their preceptorship period with the trust received mandatory training in medicine management as part of their preceptorship. During this time their competency to carry out medicine management tasks was assessed. Midwives who were not in their preceptorship had medicine management training as part of the Practical Obstetric Multi-Professional Training (PROMPT).

The service did not have a system in place to record staff competency in medicine management for midwives. The DOM told us this was something they had identified as an area of improvement and they currently working on a draft policy. However, the trust did have a policy and competency check for preparation and administration of medicines. This will be adapted to support the needs of the maternity department.

The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

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

Each clinical area had their own specified area for storing medicines. At the last inspection there had been issues relating to the temperature of a clinic area. This had been resolved by relocating and refurbishing the clinic in the delivery suite.

Staff stored and managed most medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation. Documentation for one fridge showed the temperature range was not within limits, this had been reported to estates who were acting. However, we did find one medicine on the postnatal ward that had been stored incorrectly by staff. Staff were made aware of this during the inspection, they contacted the pharmacy team to dispose of the medicine, completed a Datix incident form and shared with the whole maternity department that medicines should always be stored correctly.

Maternity

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on the digital systems for the 7 sets of records we looked at were fully completed, accurate and up to date.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff described what incidents were reportable and how to use the electronic reporting system.

The Perinatal Mortality Review Tool (PMRT) was embedded throughout the service. This ensured external staff with expertise were involved in investigations. Women were involved in investigations and had a point of contact, so they had continuity and support throughout the process.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers and the clinical governance team were aware of the criteria for reporting incidents to the Healthcare Safety investigation Branch (HSIB) for investigation and that any still birth or neonatal death required a 72 hour review. The trust had referred 5 incidents to HSIB in the last 6 months they had received 3 reports and were waiting for the other 2 to be published. Recommendations had been made by HSIB regarding home birth and guidance in telephone triage. The trust shared action plans they had but in place following these recommendations.

There were 30 incidents open over 60 days. However, there was a process to address why these incidents were still open with a view to resolve and close the incidents.

Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had several ways in which they shared learning from incidents with staff. For example, staff involved in incidents receive a hot debrief with opportunities for immediate support and learning. Incident reporting is reviewed with actions disseminated to all areas of the department. The trust had monthly newsletters for staff called “Risky business”, these newsletters advised staff of PMRT reviews, learning from incidents, safety champion feedback and security updates.

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

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Incidents often led to staff becoming involved in quality improvement projects to improve systems and processes that are in place as well as improving care.

Maternity

Managers debriefed and supported staff after any serious incident. We witnessed a serious incident debrief during our inspection. Staff were supported and asked questions about their well being as well as recognising any good practice and sharing learning from the incident.

Is the service well-led?

Good

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

Leadership

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

There was a clearly defined management and leadership structure in place. The director of midwifery and deputy chief nurse (DoM) was supported by a risk and governance lead midwife, associate director of nursing and midwifery,a consultant midwife, deputy head of midwifery, a team of modern matrons and professional practice and professional midwife advocate, as well as support from the deputy chief medical officer for women's services, Clinical Director for Maternity and Neonates, Clinical Service Lead for Obstetrics. and the director of operations for women's services. This led to joint working between leaders within maternity, the wider trust, and external agencies and bodies to maximise care provision for women and babies.

In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. Monthly maternity performance indicators formed part of the trusts integrated performance report which was reviewed by the board. The DoM attended board meetings and presented any midwifery papers/reports.

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

Leaders were visible and approachable in the service for women and birthing people and staff. Staff told us that the DOM was visible and knew all the staff by name. If there was a new starter, they would ensure to introduce themselves. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The leadership team prioritised the safety of their maternity service. As well as being supported by board safety champions and non-executive directors, the trust had safety champions based at ward level, these included matrons, consultant midwife, consultants, and a governance lead. The ward safety champions were integrated into the ward teams and would feed into the safety board as well as feeding back to staff. Both the board and the ward safety champion completed regular walk-rounds and scrutinised data and reports. All safety champions were knowledgeable

about the service and proactive about holding the leadership team to account. Staff found the safety champions approachable and keen to hear their views and experiences to drive improvement. Safety champions supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

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

The service was working on a new maternity vision, currently in draft form. This vision has 6 key objectives and a strategy to turn it into action. The trust was developing their vision and strategy with all relevant stakeholders, in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies. Away days had taken place to engage and involve staff in the vision and strategy. There are plans in place for the Maternity Voices Partnership (MVP) to engage how the strategy can be developed.

The maternity leadership team were passionate about their new strategy, particularly work they were undertaking to be a centre of excellence, as well as working towards achieving zero harm in maternity. There are also plans for an overarching safety strategy looking at moderate and severe harm and how they could be preventable. Several parts of the new strategy were already being delivered including a Rainbow Clinic a specialist service for women, birthing people, and their families in a subsequent pregnancy after a bereavement of a baby, neonatal outreach service, a transformation programme with the local maternity and neonatal system, environmental improvements to the site, a dedicated research midwifery team as well as the plans for the dedicated bereavement suite.

Another objective of the strategy was people, ensuring that the maternity team workforce is skilled and motivated including ongoing education and training, ensuring safe staffing levels, and supporting the well being of staff. Leaders talked about providing opportunities for leadership development and career progression. As well as a Midwife support worker (MSW) apprenticeship programme.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. The trust had achieved all 7 of the initial immediate and essential actions following the Ockenden review and were working towards achieving compliance with the subsequent 15 actions. Work was on going regarding consultant job plans with 50% of these achieved. The trust was working with the Ockenden compliance officer to ensure areas of compliance were recognised.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Maternity

Staff were proud of the organisation as a place to work and spoke highly of the culture. There was strong collaboration, team-working and support across all functions. There was a common focus on improving the quality and sustainability of care and people's experiences. The leadership team showed a strong organisational commitment towards ensuring that there was equality and inclusion across the service.

Staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff were proud to work for the trust and felt valued and respected by management. Staff described healthy working relationships where they felt respected and able to raise concerns without fear. The culture was one of learning and focused on improvement, not blame. Staff felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff told us they were proud to work at Birmingham Women's Hospital.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. We observed staff being respectful, with caring interactions between staff and women and birthing people.

The culture within maternity services supported staff to develop and fostered a culture of learning and improvement. Leaders led by example and acknowledged that their behaviour(s) percolated through the service. Leaders promoted openness and honesty to seek learning and assure themselves that learning was embedded.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. We spoke with staff about the culture within the service, we were told teams acted as a family, staff were supportive and friendly towards each other. There was no hierarchy between staff of different grades. Staff who identified as being from ethnic minorities told us that although they had at times experienced racism from patients and families they had been supported and not received racism from colleagues.

The trust had set objectives to increase the diversity of its staff at all levels and particularly at the more senior levels. Some of the initiatives included a mentoring programme called "By your side" matching junior staff from BAME backgrounds with more senior staff to provide mentoring and access to development and experience opportunities. Inclusion Ambassador, to support people with protected characteristics to raise concerns and a Maternity Services Inclusion And Diversity Group which focused on initiatives to improve the experience and equity for colleagues, women and families from diverse backgrounds.

The service had responded following the maternity patient survey 2021 in which women and birthing people had said they did not know about the interpreting service. The service has 4 full time interpreters who were located near the main entrance to the hospital. There were banners advertising the services as well as a digital interpreting service. During the inspection interpreters were observed to walk around the service letting staff know they were available to support.

The interpreters were part of an Interpreting and Cultural Insight team, offering support to women, birthing people, and their families from diverse backgrounds. The team included a Cultural Engagement Officer, offering community link work, diversity and inclusion training and cultural competencies awareness sessions.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. There was a Patient advice and liaison service (PALS) who worked with the formal complaints team to support women and birthing people with raising concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

The service had made changes following staff surveys over the last 12 months. The service has a staff forum where each month steps are taken to improve the workplace following feedback received during the staff survey. These changes included refurbishing staff areas, creating a well being hub and a staff changing hub and celebrating religious and culture events.

The service had 2 Freedom to Speck Up Guardians, who supported staff members to raise concerns and would work with teams to address cultural and behavioural issues within teams at the service.

Governance

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

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

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

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. Some policies we reviewed were out of date. However, the trust had a process in place for reviewing policies and this was reported at monthly quality meetings. Out of date policies had been risk assessed to see if there could be an extension given. If it was assessed not to be appropriate to extend the time between reviewing the policy, then that policy would be prioritised.

The service governance team had expanded its Risk and Governance Team in line with best practice. They work alongside the Trust Governance Team and the Neonatal Governance Team to ensure governance arrangements meet best practice guidance and regulatory requirements. This had led to the service achieving all 10 standards of the Maternity Incentive Scheme for three consecutive years. The team consisted of Lead Midwife for Risk and Governance, a Risk Lead Midwife, Audit and Guideline Midwives, Patient Experience Midwives and Digital Midwives, all of whom also undertake clinical work enabling them to keep up with clinical practice and have governance conversations with staff.

Management of risk, issues and performance

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

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

The Trust's risk management systems and processes are reviewed annually by the Internal Auditor with a consistent rating of significant assurance since 2017.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

Leaders worked closely with other local maternity departments. There were plans to cope with unexpected events.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

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

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal bench marking and comparison.

Maternity performance measures were reported through the maternity dashboard both within the Trust and across the Local maternity and neonatal system (LMNS) with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service had invested in an electronic patient record system. This system was also used by other maternity departments in the local area enabling joined up working across the LMNS, data accuracy, reporting and audit.

The information systems were integrated and secure**.**

Data or notifications were consistently submitted to external organisations as required.

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services.

In addition to working with the MVP the services had established internal engagement groups such as, Family and Patient Advisory Council, Maternity Patient Advisory Group and Neonatal Parent Advisory Group.

The induction of labour quality improvement work had included a co-produced survey to engage and listen to the experiences of women and birthing people having had an induction to drive improvement.

The service had a staff forum with online meetings to update staff as well as engage staff in conversations around how they feel the service is run or could be improved. Information from the maternity patient's survey is shared with staff at these meetings.

Leaders told us about the staff social media group where videos are shared, and staff can ask questions. Information was also shared with staff via monthly newsletters, and daily huddles.

There was staff recognition award schemes and trust star of the month.

Staff had support they could access from Freedom to Speak up Guardians, Inclusion Ambassador and Cultural Ambassadors.

The service works closely with its LMNS partners to ensure timely care for all women across the LMNS.

The Service shares learning regionally and nationally, for example, outcomes of a pilot led to the development NHS England improvement (NHSEI) nurse and midwife retention toolkit. The fetal surveillance QI work has been recognised nationally, resulting in a national Chief Midwifery Officer silver award and the project being shared at the Royal College Midwifery (RCM) Education Conference.

Leaders had identified from patient surveys the need to improve how they collected data from women and birthing people from ethnic minorities. Interpreters now support women and birthing people to give their feedback.

Maternity

The service always made available interpreting services for women and birthing people. Leaders had recognised that their interpreting service had not be as visible in the past. Leaders addressed this by moving them to the entrance of the hospital, there are posters and signage to make the service visible. There is a digital interpreting service which is always available. The interpreters who are employed by the service walk around the department making sure people were aware of the service.

Leaders understood the needs of the local population.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Quality improvement projects were embedded and a big part of staff's daily working. Projects were prominent in all areas of the maternity department. Each ward or area had their own Quality improvement board where staff had identified areas of improvement and investigated ways to resolve issues. Bigger longstanding issues that would take time to resolve were documented on the board with tickets showing the stage the project was at. When a quality improvement project had been achieved the outcomes were shared with the wider staff team and the team who had achieved the work were given a certificate to show their achievement.

Due to the services embedded approach to Quality Improvement they were able to quickly establish effective quality improvement plans when concerns or opportunities for improvement were highlighted. Some of the quality improvement programmes that had led to improved quality of care were, Caesarean section coordination, time to be seen in triage, and induction of Labour. Another area of improvement was huddle boards in every department where the full multi-disciplinary team engages in daily conversations about improvements and contributes to delivery of plans.

Outstanding practice

We found the following outstanding practice:

Diversity and inclusion were treated with high importance across maternity services.

The service had an interpreting service with 4 full time interpreters in the most used non-English speaking languages used by the local community. The interpreters were visible within the service and well utilised. Leaders had recognised the need for interpreters to support women and birthing people when giving feedback about their care. Along with the face-to-face interpreters there was also a portable digital interpreting service.

Quality improvement was embedded within the service, with several projects being undertaken by staff to improve the areas of the department that they worked within. This included quality improvement projects looking at the induction of labour and triage as well as smaller projects such as looking at the safe storage of equipment.

Maternity

The trust had a thorough and supportive programme for newly qualified preceptorship midwives ensuring they received the best training and feel supported during their preceptorship.

Areas for improvement

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

Action the trust SHOULD take to improve:

Birmingham Women's

- The service should ensure there are sufficient staff on duty to meet the needs of birthing people and release staff to attend mandatory training.
- The service should ensure all staff are up to date with mandatory training.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 4 other CQC inspectors, and 1 CQC inspection manager. There were 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.