The Royal Wolverhampton NHS Trust

# New Cross Hospital

## Inspection report

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## Ratings

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

# Our findings

## Overall summary of services at New Cross Hospital

**Good** 

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

We did not rate this location on inspection. The previous rating of good remains.

**How we carried out the inspection**

We visited the triage and maternity assessment area, the hospital birth centre, the high dependency unit, obstetric theatres, the midwifery led unit, the transitional care ward and the bereavement suit, and the antenatal ward and postnatal wards.

We observed the morning medical and multidisciplinary handover on the labour ward and the morning safety huddle in the elective caesarean section theatre briefing.

We spoke with four mothers and/or partners. We spoke with 28 members of staff, including service leads, all grades of midwives and obstetric staff, consultant anaesthetist, obstetric theatre staff, maternity care support workers, student midwives and the chair for the maternity voice partnership.

We reviewed performance information about this service before and after our inspection. We reviewed 11 sets of maternity records and four prescription charts. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, incidents and audit results.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 54 feedback forms from women. We analysed the results to identify themes and trends.

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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.

# Our findings

The Royal Wolverhampton Hospital NHS Foundation Trust provide maternity services at New Cross Hospital and local community services. Services include:

- Antenatal clinic
- Antenatal ward
- Community midwifery
- Fetal medicine unit
- Midwifery led unit
- Fetal assessment unit
- Maternity triage
- Post natal ward
- Bereavement suit
- Transitional care unit
- Obstetric theatres

# Maternity

**Good** ➔➔

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

- Staff worked well together for the benefit of women. They understood how to protect women from abuse. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using mostly reliable information systems. Staff were supported to develop skills. Managers monitored the effectiveness of the service through quality dashboards and audits.
- Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services. Leaders were focused on the needs of women receiving care and were committed to improving services.

However:

- The service did not always have enough staff with the right skills and qualifications to care for women and keep them safe. Some staff did not have in date life support skills training.
- Women accessing the triage service did not always have timely telephone access to a midwife.
- Equipment checks were not always carried out in line with trust policy. Some medicines were not stored safely.
- Not all trust policies available on the trust intranet were in date and some did not follow evidence based best practice.

## Is the service safe?

**Requires Improvement** ➔

Our rating of safe went down. We rated it as requires improvement.

### Mandatory training

**The service provided mandatory training in key skills to all staff. Some essential mandatory skills training was not in date.**

Nursing and midwifery staff received and kept up-to-date with their mandatory training. Compliance with mandatory training for most subjects was high. For example, 97% of nursing and midwifery staff completed conflict resolution training, 95% completed risk awareness training and 96% completed moving and handling training.

However, not all midwifery staff completed mandatory training in life support. The service target for compliance with life support training was 90%. However, midwifery staff compliance with basic life support levels 2 and 3 was 70% and new-born life support was 81%, though 95% of midwifery staff had completed adult resuscitation theory training.

# Maternity

Medical staff received and kept up-to-date with their mandatory training. For example, 94% of medical staff completed conflict resolution training, 86% completed risk awareness training and 80% completed moving and handling training. However, not all medical staff completed mandatory training in life support. Compliance with basic life support level 3 was 63% and new-born life support was 70%, 83% of medical staff had completed adult resuscitation theory training.

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

Mandatory training included a Practical Obstetric Maternity Training (PROMPT) study day annually with fetal heart interpretation and new-born life support as mandatory elements. Staff also attended an annual quality and safety in maternity study day which was multidisciplinary training.

Training in cardiotocography (CTG) was included in fetal monitoring study days attended by medical and midwifery staff and the service set a target of 75% of staff completing this training. At the time of inspection 57% of midwifery and medical staff had completed this study day. There was a plan to increase this to 92% by December 2022. 99% of midwifery staff had passed a competency assessment.

Midwifery staff in the delivery suite and midwife led unit (MLU) completed pool evacuation training as part of a local induction. Managers told us junior staff were not assigned to work in the midwifery led unit where some extra skills were required. If a junior member of staff was sent to the MLU to cover staff shortages, they worked under the supervision of the midwife in charge.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. 95% of midwifery and 86% of medical staff had completed training on autism awareness. 98% of midwifery staff and 86% of medical staff had completed level 1 mental health training.

Managers monitored mandatory training and alerted staff when it required updating. Practice development midwives were responsible for monitoring compliance with mandatory training and following up staff who did not attend training.

### Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. 96% completed level 3 safeguarding adults training and 90% level 3 safeguarding children training. 93% of midwifery staff had completed specialist level 3 safeguarding children training.

Medical staff received training specific for their role on how to recognise and report abuse. 83% of medical staff had completed level 3 safeguarding adults and children training.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed training on equality and diversity with 98% of midwifery staff and 91% of medical staff compliant with equality training.

# Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff completed training on Prevent, with 95% of midwifery and 89% of medical staff having completed this. Prevent is a form of training that aims to ensure the safeguarding of children, adults and communities from any threat of terrorism.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The midwifery safeguarding team were easily accessible and were visible in the department. They gave individual advice and support to staff on safeguarding concerns. Midwifery staff knew who to contact for advice. Safeguarding concerns were discussed during handovers and team meetings and any learning from incidents was shared.

Safeguarding concerns were recorded in women's electronic records which were only accessible to authorised staff. Information on domestic abuse, female genital mutilation (FGM) and mental health was recorded.

Staff had training on how to recognise FGM and knew who to discuss concerns with if required.

The midwifery safeguarding team collected data on safeguarding cases which was fed into the trust wide safeguarding board report.

Staff followed safe procedures for children visiting the ward. Visiting children were always required to be supervised by an accompanying adult.

Staff followed the baby abduction policy and undertook baby abduction drills. The last abduction drill was in July 2021.Babies were electronically tagged and doors had restricted access. There had been no security alerts in the unit in the previous 12 months.

### Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Chairs were wipeable and the flooring in the clinical areas and corridors had a flat surface and continuous return between the floor and the wall to allow for effective cleaning.

The service generally performed well for cleanliness. The trust set a compliance rate of 100% for environmental audits. Audits carried out in each area from July to September 2022 showed compliance varied from 80% in triage and the delivery suite for July 2022, to 100% in the delivery suite, triage and midwifery led unit in September 2022. The average compliance rate for the maternity service from July to September 2022 was 96%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning records were available and demonstrated the service performed frequent cleaning of all areas to prevent the spread of infection, in line with national guidance.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand hygiene sinks were available in clinical areas and staff washed their hands frequently and appropriately. There was adequate PPE available in the department and staff had received training in the correct level of PPE for different scenarios. Use of PPE was audited and results were included as part of the environmental audit, as above. Hand hygiene audits were undertaken monthly. From July to September 2022, all maternity services reported 100% compliance.

# Maternity

All women were screened for MRSA during antenatal appointments. Positive results were followed up with appropriate treatment pre hospital admission. Nosocomial infections were reported and outbreaks were investigated.

Staff followed the hospital tap flushing policy and we saw evidence that all flushing was recorded as required.

Staff cleaned equipment after contact with women and labelled some equipment to show when it was last cleaned. Equipment we checked was visibly clean.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment safely. Staff managed clinical waste well.**

The maternity service was spread out over several different areas of the hospital and leaders had identified areas where improvements were required in order to improve the safety and care for women using the service. This included a plan for re-locating all the maternity services together on the same level and increasing service capacity. Plans for a new women's unit had been discussed at trust board on several occasions, however a plan for when it would happen had not been agreed.

A refurbishment plan had been agreed to upgrade the delivery rooms on the consultant led unit to provide ensuite facilities within the delivery rooms.

The design of the environment mostly followed national guidance. The service had a triage area with capacity for seven women. Triage midwives assessed women experiencing concerns during pregnancy. It was open 24 hours a day, seven days a week. Women accessed the service by calling up for advice, by ambulance transfer or by walking into the department. No appointments were necessary.

The maternity triage unit was located on the same floor as the consultant led delivery suite and near to the maternity theatres. Staff told us they practiced transferring women to the consultant led delivery suite and that women were always escorted by a trained member of staff if this was required in an emergency. During our inspection up to four triage beds were used for pre surgery women awaiting an elective caesarean section and we were told this impacted on triage capacity. Leaders told us there was a plan in place to ensure elective women were not kept waiting on the triage ward. Triage was often full due to the acuity of the women attending the service who needed admitting to a maternity bed. Incidents had been reported where there were delays for some women in accessing a bed.

The fetal assessment unit (FAU) was open from 9am to 8pm weekdays and 9am to 5pm at the weekends. Outside of these hours women attended the triage service. The FAU saw women by appointment. There were five couches and two recliner chairs in the FAU. Staff told us this was insufficient to cater for all the women using the service. The room was a large open space and did not always allow for women's privacy and dignity to be maintained in all circumstances.

The bereavement suite was set away from the consultant led delivery suite and was used for women who had experienced a baby loss. The suite was decorated in a sensitive way and included cold cots and cuddle cots. The room had facilities for partners to stay and included an en-suite bathroom and small kitchenette for making refreshments.

The delivery suite provided consultant led care and had 12 rooms for women in labour. Each room had access to cardiotocography (CTG) and individual resuscitaires and computers.

The induction unit consisted of 10 beds and staff said it was always full.

# Maternity

The transitional care unit was used for babies receiving step down care from a high dependency area. The unit facilitated mothers to stay with their babies while they were receiving a higher level of intervention than would normally be required. The trust were trialling a device on the unit which delivered humidified, high flow oxygen, to babies requiring supplementary oxygen therapy, outside of neonatal care. This allowed newborn babies to receive oxygen therapy while being with their mother 24 hours a day.

The midwifery led unit (MLU) had five birth suites and was used for women who were designated as low risk. It was located below the consultant led delivery suite. MLU staff told us they practiced transferring women up to the consultant led delivery suite via the lift in case of emergencies. Women on the MLU were in individual rooms with ensuite facilities and 3 rooms had birthing pools. Each room had a computer so staff could maintain contemporaneous notes without leaving women. Neonatal resuscitaires and other emergency equipment were available on the MLU and there was enough suitable equipment to care for low risk women during labour and birth.

There were two theatres dedicated to the maternity service. This allowed for elective surgery to be planned while reserving one theatre for emergencies. The recovery room had two bed spaces which we were told was sufficient to accommodate the needs of the service most of the time. If a third recovery bed was required, women would be recovered in the delivery room or enhanced care room.

The antenatal clinic was open Monday to Friday from 9am to 5pm.The waiting area in the clinic was large enough to accommodate all the people using the service, including partners. There was access to bathrooms including disabled access.

Equipment was provided to assist staff with the safe evacuation of a woman from the birthing pools and staff had received training on its use to enable safe evacuations.

Women could reach call bells and staff responded quickly when called. Women told us staff were mostly responsive when they used the call bell.

The emergency buzzer was not audible in every area. This included several clinical areas, offices and corridors. This was on the service risk register and was continually monitored and some mitigations were in place. There had been no recent incidents reported as a result of the emergency buzzer not being heard.

The ventilation system in the consultant led delivery suite did not meet the standards set out in the Healthcare Technical Memorandum and there was a risk waste aesthetic gasses could affect staff and patients. Mitigations put in place did not adequately reduce the risk. This was on the service risk register and there was a plan to replace the ventilation system in the future.

The service mostly suitable facilities to meet the needs of women's families.Leaders had recognised extra capacity was needed for the maternity service. In order to manage workforce and improve patient experience, a separate area for antenatal patients had been created and post-natal and transitional care beds were grouped together. This enabled a better skill mix of staff and improved the experience for women who had not yet delivered their babies.

Leaders had assessed its preferred level of bookings to be less than 450 per month and had RAG rated the number of bookings as green, amber or red. From January to September 2022, the service had been green for one month, and red

or amber for four months each. The year average was 457 bookings per month and the highest number of bookings recorded from January to September 2022 was 549 in May. We did not see evidence of direct harm from this, although some women faced delays to their care. The service worked with other local maternity providers to ensure all woman had access to care when it was needed.

Staff mostly carried out daily safety checks of specialist equipment. The main adult resuscitation trolley was centrally located near the consultant led delivery suite and all staff knew how to access it. There were further adult resuscitation trolleys on each floor. Resuscitaires were available throughout all the clinical areas. Daily checks had been completed on the central adult trolley. In October, some equipment in the midwifery led unit was not checked every day. This included the emergency trolley, which was not checked for 5 days, the red cardiac arrest box which was not checked 3 days and one baby resuscitation unit which was not checked for 3 days from 1 October to 24 2022.

The service audited its compliance to equipment checks. In September 2022 the delivery suite compliance to daily checks on the resuscitation trolley was 90% and compliance to daily checks on the emergency trolley was 87%. The 14 resuscitaires on the delivery suite were checked on average 91% of the time in September 2022. In the antenatal ward compliance to daily checks on the emergency trolley was 94%. The service had an action plan to improve compliance with daily emergency equipment checks.

The service had enough suitable equipment to help them to safely care for women and babies. Equipment we checked had been serviced and calibrated regularly. A team of specialists stored and maintained the equipment. Equipment was not all in date. We found 2 items out of date on one resuscitaires on the antenatal ward. These were replaced immediately.

Staff disposed of clinical waste safely. Waste was collected appropriately using separate colour coded bags for general waste, clinical waste and recycling. Sharps, such as needles, were disposed of correctly and in line with national guidance. The use of sharps bins also followed national guidance. Substances hazardous to health were stored in locked cupboards and followed COSHH guidance. Sluices were not locked in all areas however all cleaning equipment was stored securely in locked cupboards.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff mostly identified and quickly acted upon women at risk of deterioration. Women telephoning the triage service were not always prioritised according to risk.**

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.Staff used the Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. We reviewed four charts and saw MEOWS had been calculated and escalated appropriately. The service did not audit its compliance to MEOWS, however incidents where a MEOWS score had been a factor were investigated. From August to October 2022 there had been two incidents reported due to an inaccurate MEOWS score or missed escalation. These were investigated and actions were identified. There was a plan to commence further quality audits which included reviewing MEOWS.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.We reviewed 10 maternity care records and saw they had all been comprehensively completed. The lead professional was confirmed, and risk factors were highlighted. For example, women with diabetes or a high body mass index.

# Maternity

Women were allocated to the correct pathway which was reassessed at each appointment to ensure the correct teams were involved in planning their care. Risk assessments were completed at every contact and there was evidence of appropriate referral. There was evidence of carbon monoxide screening in eight of the ten records we checked.

Staff monitored the baby's growth, and accurately plotted this. Staff identified babies that were at higher risk of complications. Women were screened for safeguarding concerns and staff used the information to plan care and involve the right staff. Staff ensured women understood the importance of vitamin D supplementation and monitoring their baby's movements from 25 weeks of pregnancy.

Women were risk assessed for their clinical urgency on arrival at maternity triage. Staff used a recognised obstetric triage tool in order to ensure women were treated in order of priority of need. Not all staff working in triage had completed all the training required to use the system effectively, and it was not fully embedded into practice.

The triage tool required women had a clinical triage assessment completed by a midwife within 15 minutes of their arrival. This helped to identity those in need of immediate care. Not all staff recorded the time women arrived or were seen and therefore it was not possible to ascertain accurately how many women were seen within the required standard. However, the service did monitor compliance using the data that was available. In October 2022, 72% of completed records demonstrated women were seen in triage within 15 minutes of their arrival. Staff escalated delays to co-ordinators who tried to support with extra staff when possible.

Women who called the triage service did not always have rapid access to a midwife. Telephone calls were regularly answered by administrative staff. In these circumstances, women were asked for their contact details and told a midwife would call them back. These calls were not prioritised in order of risk, or officially recorded. National guidance (NICE, 2017) recommends the provision of a dedicated triage midwife to provide telephone triage for all women contacting the service. Managers told us women were not triaged by the administrative staff who answered the calls and were always called back by a qualified midwife. However, there was no midwife dedicated to dealing with triage calls only and the two midwives working in the department were responsible for all the patients, both in the department, and on the telephone.

Some women reported to CQC they had difficulty accessing the triage service. The telephone-line did not automatically divert to an alternative number or to voicemail if calls were not answered. Women were not always called back promptly. Following our inspection, we received 12 responses from women who had used the triage service and told us they were unhappy with some aspect it, including delays to answering the telephone and delays to receiving a call back. One woman told us they went to an emergency department when they had concerns about their pregnancy due to difficulties in accessing triage.

Women arriving at triage were checked in by a ward clerk or midwifery support worker who took basic observations. The service expected this to be completed within 15 minutes of the woman's arrival. Following this, a midwife carried out a five-minute initial triage assessment and allocated the woman a rating using red, orange, yellow or green to indicate a priority of risk. The categories for each colour were defined by the triage assessment tool. Orange and red patients were expected to have a full assessment within 15 minutes and/or transfer to theatre or delivery suite and receive a medical review. Patients who were yellow or green waited up to four hours to be seen. Incidents reported that some women left without being seen and discharged themselves against medical advice.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets.Accurate compliance data to the triage recommended time

scales was unavailable. However, staff told us red and orange categories were treated quickly. Some data was collected although not yet reported on, for example, the electronic notes system recorded the time medical staff made an entry, however the information was not collected in a reportable format. The manager told us they planned to carry out more audits in the triage service once more staff had been fully trained in using the triage tool.

Clinicians monitored and reported women whose induction of labour was delayed. During times of high demand, a delayed induction pathway was implemented. The service were developing a risk prioritisation tool for making decisions on which women required their inductions urgently, and those whom could safely wait for their induction.

Staff knew about and dealt with any specific risk issues. All women were assessed for the risk of developing a venous thromboembolism (VTE). VTE treatments were prescribed when required and women were given advice on recognising the signs of a possible DVT on discharge. Staff had received training on sepsis and knew how to identify possible sepsis cases quickly. Safety checklists were used in theatres as recommended by the World Health Organisation (WHO). Compliance to WHO checklists was audited by the trust and the obstetric service achieved 100% in September 2022.

Cardiotocography was used when a baby requiring heart rate monitoring (CTG). CTG records were reviewed by second midwife to ensure these had been accurately reported and any anomalies were not missed, as per Fresh Eyes national guidance. The service audited its compliance to Fresh Eyes, which required a second checker to review CTG's every hour. From April to June 2022 results showed 11% of results audited had a recorded second checker every hour, and 89% of records had no evidence of a second checker within the auditable timeframe. These results were reviewed to identify any failings. The trust reported that some staff had not used the tool correctly and therefore unduly negative compliance was demonstrated. During the factual accuracy period the trust provided evidence of a locally implemented safety measure which showed an improved compliance. Fresh eyes had been completed correctly on the four CTG's we looked at.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). All women received an initial mental health screen when booking into the service and this was updated throughout their pathway. Specialist midwives were available for women requiring extra support. The safeguarding team provided support for staff who identified women who were at risk of deteriorating mental health.

Staff shared key information to keep women safe when handing over their care to others. Handover documents were completed using a communication tool; Situation, Background, Assessment, Recommendation (SBAR). The handover included essential information which was automatically generated from the electronic patient records system. The use of SBAR communication handover tools was not audited however managers told us there had been no incidents reported relating to handovers.

Shift changes and handovers included all necessary key information to keep women and babies safe. Handovers occurred at the start of every shift change. In addition, there were board rounds and huddles throughout the day.

### Midwifery Staffing

**The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

**The service made sure most staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

# Maternity

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The service used the Birth Rate Plus staffing acuity tool to calculate how many staff were required for the service. The acuity tool was reviewed every 4 hours during the daytime. Managers and matrons discussed staffing and acuity and declared their compliance and they moved staff to areas most at risk.

Minimum midwifery staffing levels were not always met. However, we saw evidence which showed 100% of women received one to one care in labour between January and September 2022.

Midwifery staffing was the highest risk on the service risk register and some shifts went unfilled. The service had recruited 14 new midwives and once these were in post, there would be four whole time equivalent (WTE) midwives still required. However, managers acknowledged that newly qualified and overseas midwives required extra support during the first year, and this placed additional burdens on experienced staff.

Some staff shortages were reported on the incident reporting system, especially when there were high acuity levels in the department. Some staff went without breaks and some safety checks were not completed, and telephone calls went unanswered in order to provide hands on care to women who needed it. Managers made decisions to close or reduce the opening hours in some areas when staffing became unsafe. This included the fetal assessment unit, midwifery led unit and antenatal clinics. These women would be redirected to other areas of the service including triage, or the antenatal ward.

More midwife sonographers were required to ensure women received timely access to scans. Sonography staffing was on the service risk register. The service were arranging training for staff in sonography to try and increase access.

Managers accurately calculated and reviewed the number and grade of midwives, support workers and healthcare assistants needed for each shift in accordance with national guidance. Managers monitored daily staffing numbers during daily Sitrep meetings. The meetings reviewed staffing and acuity levels and ensured midwives and support workers were moved to meet women's needs. Staffing issues were communicated throughout the day and updates were provided at handovers and during safety huddles. Additional huddles were called if required and included senior midwifery staff where escalation was required. The coordinator triggered the escalation process if staffing numbers were unsafe. Safe staffing in maternity was regularly reported to the quarterly public trust board meeting.

The service reported occasions when it was critically short of staff which had resulted in cancellations or delays to care. These were reported as 'red flags' every month. From January to 23 October 2022, the service reported 61 red flag occasions which was 8% of its activity.

The triage service did not always have enough staff with the right skills. The acuity tool used did not consider the acuity of women in the triage service as it was designed specifically for use in intrapartum areas only. Two midwives were allocated to triage every day however staff said they often worked with just one. Initial calls to the triage service were often answered by non-clinical administrative staff who did not have the training required to assess women, and there was a risk woman needing urgent care would not always be identified quickly. Administrative staff took callers names and contact details and midwives called them back when able. Out of hours, or when there was no administrator on duty, the triage midwives had to answer calls as well as carry out all the clinical tasks required on attending women. There were delays in answering some calls to triage.

The ward manager adjusted staffing levels daily according to the needs of women. The Birth Rate Plus staffing tool took into account women's acuity and managers moved staff to areas of greatest risk.

# Maternity

The number of midwives and healthcare assistants did not always match the planned number. When shortages were identified managers offered bank shifts to staff and some services were closed or reduced. For example, the midwifery led unit closed to enable safe care in other clinical areas. Other actions to mitigate shortages included calling in community midwives and managers working clinically, and this included the consultant led delivery suite co-ordinator. On the antenatal ward, the maternity co-ordinator usually had a caseload of patients as well as the co-ordinator role.

The service had low vacancy rates. In September 2022 the vacancy rate was 6.8%. This had increased from 0% vacancy rate in March 2022. Managers monitored vacancies and a maternity retention midwife worked with them. Leavers were given exit interviews. Some staff had left for retirement, including those who had stayed and worked longer than expected during the COVID-19 pandemic.

The service had low and/or reducing sickness rates. Maternity service sickness rates had reduced from 11% in January to 5.5% in August 2022.

The service had low reducing rates of bank and agency midwives. Bank and agency were used to keep staffing levels safe. Managers limited the use of bank and agency staff and requested staff familiar with the service and ensured all bank and agency staff had a full induction and understood the service before they started work. Bank fill rates were monitored and unfilled shifts were reported.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates in September 2022 varied. For example, 95% of obstetricians had received appraisals and 100% of staff working in the midwifery led unit had received an appraisal. However, in the delivery suite, the figure was 76% and in the maternity ward it was 88%. There was an action plan for managers to ensure all staff received an appraisal.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. A senior midwife was given allocated time to provide clinical supervision to staff. Practice development midwives provided mandatory training and study days.

Managers made sure most staff received any specialist training for their role.Multi-professional face to face training in emergency obstetric skill drills resumed in May 2022 following a pause during the COVID-19 pandemic. There was an updated Practical Obstetric Multi-Professional Training (PROMPT) online package also available for staff. In June 2022 all general anaesthetists who contributed to the obstetric anaesthetic rota were included in the PROMPT skill drills sessions. Theatre staff were also included.

The midwifery staff working in triage had not received specialist triage training, and there was no triage specific competency list. Most staff had received some training on the triage tool used in the department, however this was not yet fully embedded in the service.

Newly qualified midwives worked four to six weeks supernumerary while they shadowed more senior midwives. Competency booklets were provided for most clinical areas.

### Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.**

The service generally had enough medical staff to keep women and babies safe. The medical team told us they had a full complement of staff which included consultant obstetricians, registrars, and middle grade doctors. There were some

shortages in junior doctors. Locums were rarely required, or available. Some midwives reported difficulties in getting medical staff to review patients quickly. Delays were evident in the triage service where there were no medical staff based. The fetal assessment unit and the post-natal ward also reported some delays while waiting for medical input, and this included delays to women's discharges due to waiting for medical review or discharge paperwork from the medical team. Midwives reported some incidents when they had been unable to get a medical review and staff told us that women have self-discharged against advice due to the time they have been waiting. Discharge paperwork was sent to the woman's GP.

The service had a consultant on call during evenings and weekends. Consultants were on site from 8.30am to 8.30pm every day and were on an on-call rota outside of these hours. Medical staff were available on the consultant led delivery suite 24 hours a day, seven days per week. Consultants generally reviewed their own women and this had led to some women not being seen every day. However, board rounds were undertaken four times per day and women in need of a review were highlighted.

Ward rounds were attended by medical and midwifery staff plus anaesthetic staff and students. Consultants led wards rounds which were used to both review and plan women's care and for teaching and learning opportunities. The midwife co-ordinator provided verbal handovers outside of individual rooms and medical staff only reviewed labouring women if it was clinically indicated. Junior doctors and midwifery staff told us consultants were visible, available and supportive.

Managers supported medical staff to develop through regular, appraisals and constructive clinical supervision of their work. Medical staff had in-date appraisals. Junior doctors told us they felt supported by the senior team and that opportunities for learning where good in the department. Medical staff said they worked well with the midwifery teams to create a supportive environment for each other.

### Records

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

Women's notes were comprehensive and all staff could access them easily. Most information about women was recorded electronically using a national midwifery electronic patient records system. All midwifery and medical staff could assess the electronic notes system. Women with electronics devises had access to some of their maternity notes via a maternity APP.

Laboratory results were recorded on a different system. One midwife told us they did not have access to this as their password had expired and another told us the laboratory reporting system was currently down. Staff said they would ring the laboratory if results were required urgently.

Records were not routinely audited at the time of our inspection. However, records were reviewed as part of incident investigations. There was a plan to include notes audits in the monthly matron's quality audit by the December 2022. Most of the records we viewed during our inspection had been completed comprehensively.

Records were stored securely. All computers were password protected and staff closed screens when computers were not in use.

# Maternity

## Medicines

**The service used systems and processes to safely prescribe, administer and record medicines. Not all medicines were stored safely.**

Staff followed systems and processes to prescribe and administer medicines safely. All midwifery staff received training in medicine management. Newly qualified midwives were given competency workbooks and assessments before independently administering medicines. Procedures for checking the administration of controlled drugs (CD's) were safely followed. The allergy status of women was checked and this was recoded on the woman's medicines chart.

Staff completed medicines records accurately and kept them up to date. Medicines charts were paper based. The five prescription charts we looked at were legible, and administrations had been comprehensively completed with times, dates and signatures. There were no delays or gaps in administering the medicines on the charts we looked at.

CD's were checked following the trust medicine policy. Two staff always checked the stock and signed out for any medicines used in line with the policy.

There was a dedicated pharmacist for maternity services who visited the clinical areas and was available for support and advice. Out of stock medicines could be ordered and supplied quickly when required. Tablets to take home (TTO's) were supplied by pharmacy in a prepacked format. This reduced the time some women had to wait for TTO's before discharge.

Staff did not store all medicines safely. Intravenous fluids (IV's) were stored in rooms which did not have ambient temperatures monitored and recorded regularly. The IV storage rooms were very warm during our inspection.

The ambient IV room temperature on the postnatal ward was 29.9 on the day of our inspection and estate staff were present trying to cool the room. The manager told us if the room could not be cooled, another storage room would be required. This would be a longer-term plan as no other rooms were currently available. Pharmacy staff had reduced the shelf life of IV medications on this occasion (to summer 2023). However, the shelf life had only been reduced very recently and it was impossible to know how long the room had been so hot because staff had not been monitoring the room temperature. Leaders were aware of the problems associated with high temperatures in the IV storage rooms and told us pharmacy had issued each area with a thermometer. However, some staff were unaware that there was an expectation to record temperatures in the IV storage room.

Medical gases were checked and stored safely in ventilated areas away from flammable materials. They were stored securely to prevent them from falling.

## Incidents

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

Staff knew what incidents to report and how to report them. There was a clear process which all staff we spoke to understood and followed. The trust used an electronic reporting system which staff had access to. Staff understood their responsibility to report incidents that affected safety.

# Maternity

Staff received feedback from investigation of incidents, both internal and external to the service. Staff were able to tell us about incidents which they were involved with and had received feedback on. They were also aware of incidents which had been shared with and by other maternity units so that learning was shared as widely as possible.

Staff met to discuss the feedback and look at improvements to the care of women. All reported incidents were reviewed by the risk team to ensure they had been graded correctly. Incidents which required further investigation were discussed at the weekly risk meeting. Incidents were classified green, yellow, amber and red. Red incidents were reported as serious incidents, amber incidents required more in-depth reviews and route cause analysis plus action plans if necessary. Yellow and green incidents were managed locally, and any trends were monitored and investigated.

Staff were informed about incidents at team meetings, handovers and daily huddles. Staff who were not on duty had access to information about recent incidents via the maternity update newsletter and through safety briefings, emails and by the risk notice board in the department. Staff told us about changes they had implemented following a recent incident with a medication.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Women were given the name of a staff member involved in the investigation of incidents to ensure they always had someone to contact if they had any questions. Incidents were investigated and resolved as quickly as possible. In October 2022 there were 20 incidents which had been open for over 60 days. This included four incidents which had been sent to the Healthcare Safety Investigation Branch (HSIB) for further investigation. Following our inspection, we reviewed three serious incidents. These had been categorised correctly with initial actions identified and appropriate onward referral to HSIB.

Managers debriefed and supported staff after any serious incident. Debriefings took place as soon as possible after a serious incident and included all staff. Managers recognised the maternity unit staff were regularly exposed to or involved with traumatic events. Staff had access to psychological support and professional midwifery advocates which they self-referred to whenever necessary.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff understood the need to engage with families when something went wrong, and that by offering a verbal apology, this was not an admission of wrongdoing, but an acknowledgement of concerns. Managers applied formal duty of candour when required and this was monitored through audits and reported to the board in governance reports.

## 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 staff. They supported staff to develop their skills and take on more senior roles.**

# Maternity

There was a clearly defined management and leadership structure in place. The senior leadership team included the director of midwifery, the head of midwifery, the clinical director for obstetrics and gynaecology, the clinical director for neonates, and a group manager. The leadership group was well established and had worked together for some time. The team were supported by the deputy's and matrons who also formed part of the senior leadership in the service. Members of the senior team met weekly to discuss the service and any actions required were recorded for follow up. For example, replacement equipment or medical staffing. Maternity services reported quality, safety and performance results directly to the trust board.

Leaders of the service were visible in the clinical areas and staff told us they regularly visited the department and stopped to speak with women and staff. Governors and safety champions also carried out regular walk-abouts in the department. Midwives told us they would be confident to raise concerns directly if they arose during the walkabouts. Midwives were supported and encouraged to apply for more senior roles and training was available to enhance leadership skills.

### Vision and Strategy

**The service had a developing vision for what it wanted to achieve which was based on the trust wide strategy. Plans were being developed with all relevant stakeholders which were aligned to local plans within the wider health economy. Systems of monitoring were included in the plans.**

There was no vision or strategy specifically for maternity services at the time of our inspection. However, work had started on the maternity and vision and strategy and was being supported by the quality improvement team. The staff were aware of the trust overall vision and clinical strategy.

### Culture

**Staff felt respected, supported and valued and they all were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.**

Women, relatives and carers knew how to complain or raise concerns. Information about how to raise a concern was displayed throughout the service. Complaints were taken seriously and investigated fully. Feedback was provided to complainants on the actions it had implemented following investigations and information was provided on what women could do if they were unhappy with the trust's response and included the name of who to contact.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with were able to tell us about the complaints policy and how to deal with issues as they arose. Most complaints were informal and verbal and were usually resolved at the time they arose.

Managers investigated complaints and identified themes. The maternity service had received eight formal complaints from July to August 2022. Themes from complaints were identified with actions plans to improve which were shared with staff at team meetings. There was a culture of learning and improvement from complaints and defensiveness and blame were avoided. Staff were able to give examples of changes the service had implemented following concerns raised by women.

We spoke to five women during our inspection. All were happy with the quality of care they had received and praised staff for being kind and caring. However, short staffing and delays were mention by four of the women. Following our inspection, CQC received 54 contacts from women using the service, 32 of which were complaints about the service, 17

were mixed with both positives and negatives comments, and five were compliments. Most of the contact information came from women who had used the service from January to October 2022. Themes from the information we received included 20 complaints which mentioned staffing shortages and/or staff attitude across the service, and 12 which related specifically to the triage area.

Most staff we spoke with during our inspection were very positive both about working in the maternity service and about working for the trust overall. All staff said they were very proud of the role they had in caring for women. Midwives and doctors described a culture of sharing and learning from each other and they told us they had respectful relationships with the multi-disciplinary team.

A minority of staff said they felt they had not always been treated equally or listened to when they had tried to raise a concern. CQC received several anonymous whistle blowing concerns about the culture within the service. Managers told us they had a proactive approach to concerns raised and had been working closely with staff in the department to address any behaviours which were not aligned to the trust values. We were told that all staff must demonstrate the trusts value of being kind are caring, and that those who failed to do so would be addressed. There were ongoing actions in place for continued monitoring and staff survey results were closely reviewed to identify any trends in behaviour. Staff survey results were discussed widely with all staff working in the service.

Staff were well supported during the pandemic and managers made arrangements for vulnerable staff to have different roles. Many staff had agreed to work longer hours and during days off to cover colleagues however many now said they felt exhausted and that it was difficult for anyone to work extra hours. They said many of the new recruits were very junior, newly qualified or overseas midwives which placed extra pressure on experienced staff.

Service leaders told us they had scheduled regular engagement sessions, but the maternity service teams had not attended due to workforce pressures. Leaders had since then adopted more informal feedback mechanisms including shop floor conversations and a closed social media group. There were plans to work with the communication team to ensure feedback was robustly captured.

### 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**.

Information was captured and used to monitor the quality of the maternity service. The maternity dashboard was comprehensive and captured 50 different metrics. This included information on workforce, maternity morbidity, perinatal morbidity and mortality, readmission rate, number of complaints and number of babies born each month. The dashboard was RAG rated red, amber and green so leaders could see at a glance any metrics which were outside of expected ranges.

The dashboard was reviewed at the monthly maternity clinical governance meeting, and some information was presented to the trust integrated performance report. The dashboard was presented to the trust board and reviewed by the board and executive team. Specific maternity papers relating to national schemes and reports including the maternity incentive scheme and Ockenden reports (2019, 2022) were presented to the board.

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. There were clearly defined reporting avenues. Incidents, risks, performance,

guidelines, audits and user experience were discussed at the weekly obstetric risks group and at maternity governance meetings. These fed into divisional meetings and fed to trust wide committees and to the board. The director of midwifery or head of midwifery represented the maternity services directly at trust board meetings and was accountable for all reporting.

Maternity services were involved in the trust's quality improvement plans and fed into the divisional business forum. Current areas of focus included sonography, theatre efficiency, phlebotomy and antenatal improvement work.

Policies were not all up to date and some guidelines did not follow national evidence-based practice. Leaders told us out of date policies and guidelines had been rewritten and ratified and were awaiting upload to the trust intranet. Staff were aware some of maternity policies on the intranet were out of date. However, they told us any changes to guidance were discussed at team meetings and in departmental updates, and that they knew how to access current recommendations and guidance from professional bodies online. The trust had an action following a peer review to work with the Local Maternity and Neonatal System (LMNS) to ensure guidance was consistent across the region and that is was evidence based. The trust planned to carry out risk assessments where local guidance differed from national guidance.

### Management of risk, issues and performance

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

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included. The risk register included information relating to; staffing, including midwives and sonographers; infrastructure, including air quality and emergency buzzers; and clinical, including blood gas analysis and immunisation uptake. Risks were discussed and updated at clinical governance meetings.

The trust monitored the number of incidents and serious incidents reported every month. These were discussed at the maternity clinical governance meetings and any themes or trends were identified. An updated action log was produced following each meeting with named staff identified to carry out tasks. The trust reported compliance with and participated in the National Guidance and National Confidentiality Enquiry.

Staff understood the duty of candour (DoC). They were open and transparent and gave women and families a full explanation when things went wrong. Staff explained what had happened and apologised. Leaders assessed the application of the DoC against all incidents and maintained and monitored compliance through the maternity dashboard.

The service participated in relevant national clinical audits and had a comprehensive audit plan. Reasons for carrying out the audit was clearly indicated on the plan, as well as a priority score. Most audits on the plan were high priority and were mapped to trust objectives

Audits included compliance to NICE guidance, plus local audits and quality improvement audits.

NICE audits included for example, CTG in Labour Audit CG190 Intrapartum care for healthy women and babies; and the NICE Multiple Pregnancy Audit- CG129 and QS46 Caesarean Sections. National audits included the Diabetes in Pregnancy Audit 2022, and the National Maternity and Perinatal Audit.

# Maternity

Local audits included an audit of handover processes on the delivery suite and an audit of consent.

Audit results for the Perinatal Mortality Survey and Perinatal Quality Surveillance were not available at the time of our inspection.

The trust received an Ockenden Insight Visit in August 2022 and the findings were reported to the trust board in October 2022. The report was largely positive and found 13 points for celebration, including strong leadership and good surveillance and oversight of the service. There were seven points for consideration which mainly related to strengthening audit process around Saving Babies Lives Care Bundle, v2. Leaders told that they had begun working on these points immediately after the Insight visit.

### Information Management

**The service collected mostly 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.**

Performance measures and key performance indicators (KPIs), were monitored, including the maternity dashboard and clinical area KPIs.

Dashboard parameters were presented in a way which allowed leaders to challenge practice in order to make suggestions for improvement. The parameters had been set in agreement with local and national thresholds. Leaders benchmarked their performance against other NHS maternity services locally and nationally.

Data was submitted to external bodies including the National Neonatal Audit Programme, MBRRACE-UK and HSIB.

Data to support higher risk women was recorded at all booking appointments. This included women's ethnicity, and postcode to highlight areas of social deprivation, and other risk factors or co-morbidities. This data was used in planning women's care regionally to ensure the right services were being offered where they were needed most. Managers used this information to inform decisions around all aspects of service delivery including continuity of care teams and community caseloads.

Most data collected was reliable except for the waiting times and treatment times in the triage service which was not accurate. Further training was planned to address this.

Women's notes and records were mostly digital, with medicines charts being written on paper. The service planned to implement an England wide single pregnancy record in 2023. Single pregnancy records allowed all hospitals in the scheme to access the one pregnancy record. The trust was working closely another local NHS provider and the Local Maternity Services Network (LMNS) to implement the single pregnancy record. Digital midwives and digital leads within the LMNS led this work.

### Engagement

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

Senior staff in the service engaged with partner organisations to help improve services for women.

# Maternity

The trust was an active partner in the Local Maternity and Neonatal System (LMNS) where it worked with other local maternity units, to achieve personalised, and safer care for women. The LMNS shared learning and good practice across the region to improve consistency of safe care and to ensure pregnant women had access to up to date evidence in order to make choices about care.

The trust worked with the Wolverhampton Maternity Voices Partnership (MVP) who they met regularly. The aim of the MVP was to implement local ideas for improving maternity care and to ensure equality and diversity and social mobility was considered in the designing and planning of services. The MVP included representatives from health protection agencies, breastfeeding specialists and other experts to help share maternity initiatives or changes to national guidance. The overall aim of the collaboration was to improve the lives of mothers and babies. MPV contact details were displayed on notice boards in the department.

The MVP chair had access to maternity leaders in the trust and to the trusts' community equality and diversity midwife.

The equality and diversity midwife worked with hard to reach women and families. For example, women living in hostels and women whose first language was not English and those without access to technology including the internet. Interpreters were available in languages appropriate for local service users. The service engaged with same sex couples and surrogate mothers through the equality and diversity midwife.

There was a cultural ambassador for maternity services which all staff had access to. Leaders told us they were committed to ensuring the culture was right across maternity service in order to protect the safety of women and babies. Trust leaders worked with the maternity service safety champions and Freedom to Speak up Guardians (FTSUG) to ensure concerns raised were dealt with and any actions identified were implemented rapidly. These groups along with contact details were posted throughout the maternity service. The trust shared themes from the FTSUG with staff through emails and newsletters.

Information boards on corridor walls were available in all clinical areas. Information included user feedback and actions taken, contact details for various groups including the Patient Advice and Liaison Service for complaints and how to provide feedback to the Care Quality Commission.

Staff working in the service were immediately identifiable by large yellow name badges and new starters badges included the text 'I'm new here,' to raise awareness and help staff to support new colleagues.

### 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.**

The service's transitional care ward were using a quality improvement project to trial the use of high flow warmed vaporised oxygen outside of the neonatal unit. This allowed neonates requiring supplemental oxygen therapy after birth to remain with mother instead of being cared for in a neonatal unit.

The trust's home phototherapy service enabled some babies who required light therapy to receive this at home due to the service's equipment lending facility. This allowed babies with jaundice to be treated outside of the hospital environment.

# Maternity

The service were continually improving the service through learning from incidents. This included locally investigated incidents and those referred to the Healthcare Safety Investigation Branch.

Mandatory training methods had been updated following the COVID-19 pandemic. This had led to increased virtual learning packages online. These were more accessible to those working both clinically, and remotely and staff said the packages were interactive, informative and enjoyable. Women testing positive for COVID-19 had access to midwifery and medical staff through remote monitoring to keep them safe.

Leaders of the maternity service recognised the infrastructure of the department required updating or reconfiguring in many areas. They were passionate about seeking funding for a purpose-built maternity unit.

## Areas for improvement

**The maternity service must:**

- The service must ensure women telephoning the triage service have rapid access to an initial assessment by suitably trained and qualified staff. (Regulation 12 (2)).
- The service must ensure they maintain safe staffing numbers in all areas of the maternity service. (Regulation 18 (1)).

**The maternity service should:**

- The trust should ensure that all staff complete mandatory training and role specific training in a timely way.
- The trust should ensure all emergency equipment checks are carried out in line with trust policy.
- The service should ensure the emergency buzzer is audible in every area.
- The service should ensure the ventilation system in the consultant led delivery suite complies with the standards set out in the Healthcare Technical Memorandum and that all risks from waste aesthetic gasses are adequately mitigated.
- The service should ensure all medicines are always stored safely.
- The service should ensure there is a continued improvement in the system of review for all cardiotocography fetal monitoring, including appropriate documentation of Fresh Eyes checks.
- The service should ensure policies and guidelines are updated and available to staff within agreed timescales. Local guidelines differing from national guidelines should have been risk assessed.

# Our inspection team

**Our inspection team:**

The team that inspected the service comprised a CQC lead inspector and four other CQC inspectors and two specialist midwife advisors. The inspection was overseen by Caroline Jenkinson, Head of Hospital Inspection.