University Hospitals Bristol and Weston NHS Foundation Trust

UHBW Bristol Main Site

Inspection report

Bristol Royal Infirmary
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Date of inspection visit: 5 and 6 December 2023
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Ratings

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

Our findings

Overall summary of services at UHBW Bristol Main Site

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 St Michael's Hospital, University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) main site.

We inspected the maternity service at St Michael's Hospital, UHBW main site. 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.

The St Michael's Hospital, UHBW main site provides maternity services to the population of Bristol and the surrounding areas.

Maternity services include antenatal clinic (including fetal and maternal medicine), a day assessment unit, community midwifery care, an 18-bed central delivery suite (which includes a 3-bed recovery bay, a 2-bed triage unit and 1 bereavement suit), a midwifery led birth unit, two maternity theatres, a mixed antenatal and postnatal ward and a transitional care ward. Between October 2022 and September 2023, 4329 babies were born at St Michael's Hospital, UHBW main site.

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

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

Our rating of this hospital stayed the same we rated it as Good because:

- Our rating of Good for maternity services did not change ratings for the hospital overall. We rated maternity services Requires Improvement for safe and Good for well-led.

We also inspected 1 other maternity service run by University Hospitals Bristol and Weston NHS Foundation Trust. Our reports are here:

- Weston General Hospital - Care Quality Commission (cqc.org.uk)

How we carried out the inspection

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

We visited the central delivery suite, maternity triage, day assessment unit antenatal and postnatal wards.

We spoke with 15 midwives, 5 obstetric consultants, 3 doctors training in obstetrics and gynaecology and 2 student midwives.

Our findings

We received 39 responses to our give feedback on care posters which were in place during the inspection. Of these responses, 8 were positive and 29 included concerns about the service. Where women and birthing people raised concerns about the service themes included the quality of postnatal care, communication and induction of labour.

We reviewed 8 patient care records.

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

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

Maternity

Good ➔➔

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

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

However:

- Staff had not always completed updates to safeguarding level 3 training.
- Staff did not always complete checks of emergency equipment.
- The service did not always review incidents in a timely way.
- Midwifery staffing levels overall impacted on staffing levels on the postnatal wards and the availability of midwifery led care on the alongside birth centre at St Michael's.

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

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

Midwifery staff received and kept up to date with their mandatory training. 88% per cent of staff had completed all 12 core skills mandatory training courses against a trust target of 90% and 91% of staff had completed all 19 remaining mandatory training modules against a trust target of 90%.

Maternity

Medical staff received and mostly kept up to date with their mandatory training. 77% per cent of staff had completed all 12 core skills mandatory training courses against a trust target of 90% and 76% of staff had completed all 19 remaining mandatory training modules against a trust target of 90%.

The service made sure staff received multi-professional simulated obstetric emergency training. The practice development team regularly reviewed the contents of obstetric emergency training to include learning from incidents at the trust. For example, learning from an incident in relation to diabetic ketoacidosis (also known as DKA, a serious condition that can happen in people with diabetes) had been used in scenario 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 neo-natal life support. 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.

The lead consultant for fetal monitoring ran an annual training day, on which escalation was covered, along with human factors and civility. Staff received training on measuring symphysis fundal height and plotting on growth charts as part of the fetal monitoring study day. The teaching rota included short sessions for trainees between 7:30 and 8am. Topics were usually by the trainees. Following the Ockenden report a week of drop-in sessions had been held to explain what it was about and what was being done in response by the service leads.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

Staff understood how to protect woman and birthing people from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, not all medical staff had completed safeguarding training updates.

Midwifery staff received training specific for their role on how to recognise and report abuse. Training records showed that 69% of midwives had completed 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.

However, safeguarding training compliance for medical staff obstetric consultants needed to improve. As of 15 December 2023, 84% of obstetric consultants and 9% of obstetrics and gynaecology junior doctors had completed safeguarding children level 3 training updates. The service had recognised compliance with medical staff safeguarding training as a risk since June 2014. The risk was mitigated by increased training sessions and the trust told us the 3 consultants who had not completed the training were booked to complete this in February 2024. Following the inspection, the trust told us they were pursuing solutions to allow junior doctors can use a 'passport', which acknowledges prior training in previous rotations. This was because junior doctors rotate frequently and the suggested solution would help ensure junior doctors had the required mandatory training, including level 3 safeguarding training wherever they were working on their training rota.

Staff could give examples of how to protect woman and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Assessment of potential risk was carried out at all stages of the pregnancy and flags were placed in notes, so staff were able to see information. Huddles in the morning and end of the day at staff handovers included sharing information related to safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could name safeguarding leads.

Staff followed safe procedures for children visiting the ward. The checking of access to the ward and exit included safety checks of who was coming in or going out and with whom. The baby abduction policy was followed by staff, and they undertook baby abduction drills. Staff were reminded in the September 2023 women and children's patient safety newsletter about the importance of not allowing anyone to tailgate as this was a theme from abduction simulations.

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.

Although antenatal and postnatal ward areas on level E looked tired, with noticeable damage to skirting boards and paintwork, they looked visibly clean and had suitable furnishings which were clean and well-maintained. Domestic staff worked routinely on the ward and told us they had the right equipment to carry out their duties safely and fully. They understood their responsibilities. Cleaning records were displayed and showed what was expected to be carried out. Once tasks had been completed, the record was updated.

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.

There was access to infection prevention and control policies in hard copy on the ward. We noted the policy for isolation, resistant and alert organisms expired in January 2020. Not all staff could confirm if there was an infection control lead in maternity.

Staff followed the dress code, which included having bare arms below elbow, wearing a uniform and having hair tied back or up. Staff were seen applying infection control principles including the use of personal protective equipment (PPE). We saw there was good access to handwash and drying facilities, hand sanitizer and noted staff used these regularly. Gloves, aprons and face masks were available in all areas. After use PPE was disposed of correctly in the right bin.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were not always completed every month in all maternity areas. For example, on central delivery suite hand hygiene audits were not completed in June, July, September or October 2023. While the ward areas consistently scored 100% in hand hygiene audits the November 2023 hand hygiene audit compliance on central delivery suite was 80%.

We noted staff cleaned equipment after use and attached labels to items showing when it was last cleaned. The cleaning of some equipment which did not necessarily come into contact with women or birthing people required attention. For example, we found thick dust on the lower wheels of the resuscitation trolley, dust on a defibrillator and oxygen cylinder holders. The top of an incubator was very dusty.

Disposable curtains, which were dated when hung surrounded bed areas. These were seen to be clean.

Clean bed linen was stored safely and away from areas where they may be at risk of contamination.

Maternity

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 design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff did not always carry out daily safety checks of specialist equipment. Records showed neonatal resuscitaires on central delivery suite were not always checked daily in November 2023. We raised this with the service following inspection and the service told us there was a plan to move paper checklists to an electronic system that would automatically alert midwives in charge to the possibility of missed checks.

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.

The service had processes to ensure equipment was maintained and tested for electrical safety, demonstrating it was fit for purpose and safe for patient use. Electrical safety checks had been completed on equipment we looked at.

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

The quality of the environment on level E of St Michael’s hospital, which included the antenatal waiting room and clinic rooms, was a recorded risk. A planned refurbishment had been delayed due to the COVID-19 pandemic. The risk was reviewed every 3 months, and the refurbishment was in the 5-year plan.

The service carried out regular risk assessments including an environment ligature and self-harm risk assessment of the maternity areas. A ligature risk assessment of the environment was last carried out in September 2023. Staff had access to ligature cutters on all emergency trolleys but not all midwives we spoke with were aware of this.

Assessing and responding to risk

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

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed a monthly audit of a sample of records to check they were fully completed and escalated appropriately. Audits for December 2023 showed on the antenatal and postnatal ward and on the central delivery suite MEOWS was completed and escalated appropriately 100% of the time.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The maternity triage waiting times for review audit of 116 cases between 3 July and 17 July 2023 showed

midwives reviewed 84% of women and birthing people within 15 minutes of arrival, 94% were assessed by the midwife within an appropriate time frame (determined by the triage category). However, timeliness of doctor review needed to improve as where doctor review was needed in 76% of cases, 38% were not seen within an appropriate timeframe. Following the audit, the service had an action plan to improve doctor's awareness of the triage tool and improve documentation of times of reviews. The service was also reviewing staffing of the triage area to support the busiest period between 12:00 and 20:00.

At the time of inspection there was not a dedicated triage phone line. A member of the central delivery suite ward clerk answered the phone and took contact details and an NHS number and arranged for the triage midwife to call back as soon as possible. The service monitored timeliness of triage phone call response times. The November 2023 triage phone call audit showed of 310 calls included in the audit only 54% of women and birthing people were called back within 5 minutes, 15% were responded to within 5-10minutes and 15% 10-20 minutes. The remaining 16% waited over 30 minutes for a call back. The service planned to launch a dedicated triage phone line in January 2024.

Medical staff prioritised inductions of labour in order of clinical risk regularly on central delivery suite. We saw during the inspection medical staff reviewed inductions of labour as part of morning handover. Midwifery managers also discussed inductions of labour at the daily flow meetings.

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 how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The service re-audited fetal monitoring effectiveness following the implementation of an electronic records system. The October 2023 audit showed staff did 'fresh eyes' at each hourly assessment in 94% of cases. However, the fetal monitoring audit did not include information in relation to how quality of CTG interpretation and management plans were assessed. The service planned to introduce a new monthly fetal monitoring in labour audit that had been agreed across the local maternity and neonatal system in December 2023.

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 woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. The service audited compliance with use of the SBAR handover format. The service monitored compliance with use of the SBAR format every month. Audits for December 2023 showed on the antenatal and postnatal ward and on the central delivery suite SBAR was used correctly 100% of the time.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information.

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

Maternity

The service provided transitional care for babies who required additional care.

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 timeframes and national targets.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of woman and birthing people and babies at risk. The service did not monitor staff 'red flags' in line with national guidance. However, the service had low turnover rates and good retention rates.

Midwifery staffing levels impacted on the availability of the alongside midwifery led unit. The midwifery led unit was staffed from the 11 midwives assigned to central delivery suite. Two midwives would go up to the midwifery led unit if there was a birthing person wanting to use the facility. Staff discussed the use of the facility in the November 2023 central delivery suite working party meeting exploring the possibility of having a core team of midwives managed by a band 7 midwife to more sustainably staff the midwifery led unit and support junior staff to maintain their skills in vaginal deliveries.

The service did not effectively monitor 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. Midwifery staffing incidents were reported on the perinatal quality surveillance matrix but there was a lack of oversight of the types of staffing incidents that had occurred and the impact on patient safety.

Delays in the induction of labour process and the potential risks to patient safety was reported as a risk in the quarterly exception report for July to September 2023. However, the trust did not have an effective way to monitor delays to induction of labour. We reviewed the perinatal quality surveillance matrix for October 2023 and found the enhanced dashboard for 2023 included a data category for induction of labour breeches but no data was included between January and October 2023. Following the inspection the service submitted data to show the dashboard had been improved after the move to electronic records. From November 2023 the dashboard included data on delayed induction of labour. Managers did not monitor and compare maternity red flag incidents in the 6 nursing and midwifery staffing reports to trust board in line with national guidelines.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in June 2022. This review recommended 211.73 whole-time equivalent (WTE) midwives Band 3 to 7 compared to the funded staffing of 216.04 WTE, so the service had an additional 4.31 WTE staff than recommended at the time of the review.

Managers reported staffing levels to the quality and outcomes committee every month. Across the women's division in October 2023 the nursing and midwifery fill rate was 91% during the day and 92% during the night. The October 2023 staffing variances report showed staffing on central delivery suite was prioritised to maintain one to one care in labour in line with national guidelines and as part as a whole unit approach to patient safety. This impacted on the midwifery staffing on the antenatal and postnatal wards, ward 73 and ward 76. For example, the registered midwifery staff fill rate during the day was 73% on ward 73 and 46% on ward 76 in October 2023.

Maternity

Midwifery staffing data was reviewed every month and reported in detail to the trust board every six months. The last six-monthly staffing review was reported to board in January 2024. The report noted that plans for a new triage unit being built in maternity would require 5.6 WTE midwives to be funded to provide a 24hour triage service.

As of November 2023, there were 18.9 WTE midwifery vacancies with a projected vacancy rate of 9.9 WTE once new starters commenced.

On the day of inspection, the maternity service was staffed as planned with 11 midwives covering the central delivery suite, recovery and triage areas, supported by 2 midwifery support workers.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. The central delivery suite used a maternity staffing and acuity tool to monitor safe staffing levels every four hours.

Maternity managers could adjust staffing levels daily according to the needs of woman and birthing people. Managers moved staff according to the number of woman and birthing people in clinical areas. The women and children's service had two flow meetings a day at 10am and 4pm to review staffing and levels of activity. Matrons or senior midwives from all areas of the maternity service attended these meetings. Staff were supported to manage midwifery staffing levels as safely as possible using the escalation or closure checklist and guidance document.

The service had low turnover rates. At the time of inspection, no band 5 midwives had left the service in the past 18 months. The service had a recruitment and retention midwife and a team of practice education facilitators who supported midwives and especially newly qualified staff.

Staffing levels were affected by staff on maternity leave. As of November 2023, there were 11.92 WTE Band 6 Midwives on Maternity leave with 2.24 WTE who returned to work in September 2023. There were 1.5 WTE band 7 midwives on maternity leave.

Staffing levels impacted on the services ability to provide continuity of care. At the time of inspection as of 2 October Granby Oak continuity of care team had been disbanded for 8 weeks due to staffing issues. The trust made the decision to maintain the safety of the maternity service overall during a period of reduced staffing.

The sickness rate was below the trust target of 5%. As of August 2023, the midwifery staff sickness rate was 2.7%.

Managers requested bank staff familiar with the service and made sure all bank staff had a full induction and understood the service. The service did not use agency staff.

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.

Managers supported staff to develop through yearly, constructive appraisals of their work. As of October 2023, 71% of midwifery staff had received a yearly appraisal. A practice development team supported midwives. The team included 5 practice education facilitator midwives.

Managers made sure staff received any specialist training for their role. For example, the service had developmental band 7 roles to support with succession planning in the service.

Maternity

Two nurses from the trust had started the Health Education England funded 20 month shortened midwifery training programme and the trust had secured funding for a further two posts.

The service had 48 NIPE trained staff. There were no reported delays to NIPE in October, November or December 2023.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. At the time of inspection, the service employed 21 obstetric consultants and 39 doctors training in obstetrics and gynaecology.

The service had low rates of bank and locum staff. 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.

The sickness rate was below the trust target of 5%. As of August 2023, the maternity medical staff sickness rate was 0.12%.

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

Records

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

The service had not audited the quality of completion of records in the past six months due to the move from paper to electronic records in September 2023. The service audited the documentation of certain aspects of clinical care relevant to the audit programme. For example, accurate time documentation in maternity records was audited in September 2023.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust had moved to an electronic records system in September 2023. We reviewed a sample of 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.

Medicines

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

Maternity

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

Staff reviewed each woman's medicines regularly and provided advice to woman and birthing people and carers about their medicines. 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 could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all 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 the service had a system to centrally monitor the temperatures in drug cupboards. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff had access to medicines used to respond to emergencies safely. However, we found on the midwifery led unit staff did not always check emergency 'grab boxes' to respond to conditions such as pre-eclampsia, post-partum haemorrhage (PPH) and cord prolapse were checked and ready for use. For example, there were 6 daily checks missing in October and 5 daily checks missing for the PPH box on the midwifery-led unit in November 2023.

Incidents

Managers did not always review incidents in a timely way.

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave woman and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Incidents were not always reviewed in a timely way. We reviewed three maternity rapid incident review meeting records and found that there was 11, 31 and 54 working days between the incidents and the review meetings. This was not in line with the trust standard operating procedure for the patient safety rapid incident review meetings, which stated the meeting should occur within 1 week (5 working days) following identification of the incident, to maximise the learning potential and obtain the facts for the patient/ family if the incident meets Duty of Candour criteria.

Managers monitored the numbers of incidents reported to monitor the incident recording culture. This data was reported in the quarterly quality exception report from Women's Division to Clinical Quality Group. The Quarter 2 (July to September 2023-23) showed that the Women's Division was the highest reporter of incidents across all the divisions in the trust demonstrating a positive reporting culture. Managers also monitored timeliness of incident review and closure at this meeting. There were delays to closing incidents. At the time of the inspection, there were 198 maternity, obstetric or neonatal incidents that had been open for more than 60 working days. The oldest unclosed maternity incident was from September 2022.

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 could describe what incidents were reportable and how to use the electronic reporting system.

Maternity

There were a high number of incidents reported in maternity in relation to the availability of interpreting services. There was a trust level risk in relation to the interpreting service used by the trust.

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

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 4 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 4 investigations, managers shared duty of candour and draft reports with the families for comment. Managers had effective processes for monitoring progress of investigations completed by the Maternity & Neonatal Safety Investigations programme. The director of midwifery and patient safety manager wrote a quarterly report to trust board to provide oversight of learning from local and external maternity incident investigation.

The trust made 11 referrals to the maternity neonatal safety investigation programme (MNSIP) between January and November 2023. We saw examples of improvements to practice following external incidents investigation. For example, recommendations were shared in the July 2023 women's services patient safety newsletter in relation to monitoring and documenting maternal pulse during the second stage of labour.

Managers reviewed incidents potentially related to health inequalities.

Staff reported serious incidents clearly and in line with trust policy.

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

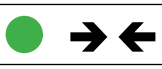
Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to the care of woman and birthing people.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident.

Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good 

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

Maternity

Leadership

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

Maternity services were managed as part of the Women and Children's Division of the trust.

The service was led by a clinical lead for obstetrics and gynaecology, a director of midwifery and a divisional business manager. They were supported by a deputy director of midwifery, and three matrons with responsibility for community services, inpatient services and the central delivery suite. The director of midwifery was also supported by a quality and patient safety manager.

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 woman and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The 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 service was supported by maternity safety champions and non-executive directors. Maternity safety champions attended a monthly safety champion production board meeting. We reviewed the minutes of the November 2023 meeting and saw discussion about current safety issues in the department such as delays to induction of labour and scanning capacity were discussed.

They 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 had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. The service had a 'strategy on a page' document for maternity services at St Michael's Hospital as part of the trust 2020 to 2025 strategy. Strategic aims included but were not limited to investing in staff wellbeing, delivering integrated maternity services and embedding a culture of research.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The strategy included closer working with the other acute trust in the city as part of the Acute Provider Collaborative (ACP). Part of this work was ensuring the same maternity digital records system was used across the city. A joint clinical strategy had been developed as part of the ACP with maternity services being one of four agreed areas chosen as a priority area for collaboration.

The service also had a digital maternity strategy that had been written with local stakeholders. Key priorities included but were not limited to empowering citizens with access to their maternity health records, using data to improve health outcomes and improving care to ensure care is received at the right time in the right place.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations.

Culture

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

Staff felt respected, supported, and valued**.** Staff were positive about the department and leadership team and felt able to speak to leaders about difficult issues and when things went wrong. We observed an especially positive culture of teamwork between medical and midwifery teams.

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.

Leaders understood how health inequalities affected treatment and outcomes for woman and birthing people and babies from ethnic minority and disadvantaged groups in their local population. 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. Senior leaders had attended the 'Black Maternity Matters' course supporting midwives to reduce the inequitable maternity outcomes faced by Black mothers and their babies. The course was a six-month anti-racism education and training programme, examining a range of topics including unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women. The director of midwifery and the clinical obstetric lead had completed this training at the time of inspection alongside other midwifery staff from across the local maternity and neonatal system.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment. The service had invested in diversity and inclusion practice educator role.

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. We reviewed summary information in relation to 11 formal and informal complaints the service received between September and November 2023. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in woman and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. The service had some challenges in responding to complex complaints in the agreed timeframes and this risk was mitigated by a complaint's coordinator starting in post in November 2023.

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 monthly Women's Governance meeting. The main themes from complaints were waiting times and communication.

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

The service had taken part in the national NHSE culture survey, studied the findings, developed an action plan which was being monitored by the Board.

Scores for the trust in the 2023 General Medical Council National Trainee Survey (GMC NTS) were significantly higher (better) than the national average for 3 indicators – Clinical supervision out of hours: local teaching and rota design.

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 governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of meetings. However, there were lots of governance meetings and there was potential for the governance to be streamlined.

We reviewed the last three St Michael's Hospital leadership team meetings and found managers, clinical directors and matrons met to discuss quality and performance issues relevant to maternity, neonatal intensive care and gynaecology services.

We reviewed the last 3 Women's Governance meeting minutes and found a standard agenda was used to discuss risk management, guidelines, compliments and complaints, assurance and action. Leaders monitored progress through an action tracker that was reviewed at each meeting.

Antenatal, postnatal and central delivery suite working party meetings fed issues up to the Women's Governance meeting. Representatives from each working party gave updates at the monthly Women's Governance meeting.

The service had a monthly Perinatal Mortality Review tool (PMRT) meeting, but it was not clear from the minutes that this was attended by a multidisciplinary team. The trust told us these meetings were recorded so there were no formal minutes. There was an ongoing action tracker to monitor learning and improvements.

At the time of inspection, the service had vacancies in the Quality and Patient Safety Team. The service had a recorded risk in relation to the risk that standards associated with the perinatal mortality reporting tool are not met due to lack of resources. There were delays to reviews of deaths using the Perinatal Mortality Review Tool (PMRT) neonatal deaths due to staffing in the governance team.

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.

Maternity

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies regularly to make sure they were up to date. Staff discussed updates to guidelines at the monthly maternity clinical effectiveness meeting.

The service had a Perinatal Transformation Board which had oversight of progress from all recent national maternity reports.

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 woman and birthing people's outcomes.

The service submitted data to NHS England Clinical Quality Improvement Metrics (CQIMs), a set of metrics derived from the Maternity Services Dataset for the purpose of identifying areas that may require local clinical quality improvement. Of the six key metrics we review, results at the trust were higher than the national average and in the upper 25% of all organisations, for one metric: women who had a PPH of 1,500ml or more (45 per 1,000 vs 31 per 1,000 nationally). In July 2023 the post-partum haemorrhage (PPH) forum was reinstated to review PPH rates and identify areas for improvement in prediction and management of PPH.

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. Staff discussed audit results and actions following audit at quarterly obstetrics and gynaecology audit meetings.

Leaders monitored key performance metrics through the trust perinatal quality surveillance matrix. The matrix was a standard agenda item on the women’s monthly governance meeting and the St Michael’s governance meeting, but it was not clear from the minutes how the matrix had been discussed and used to monitor and improve the service.

The service had a ward accreditation programme to review performance against an accreditation for quality care tool.

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

Top risks in maternity services included: delays to induction of labour, delays to assembling a second theatre team and the cardiotocography (CTG) machines not recording maternal pulse.

The delayed induction of labour risk was mitigated by regular clinical prioritisation and assessment of women and birthing people affected by delays to induction of labour by telephone or in the day assessment unit if appropriate. Following the inspection the service submitted data to show the perinatal quality matrix dashboard had been improved after the move to electronic records. From November 2023 the dashboard included data on delayed induction of labour.

Maternity

The risk that cardiotocography (CTG) machines did not record maternal pulse which could result in a delay in diagnosing issues with fetal wellbeing. The risk was mitigated by monitoring maternal pulse on admission, on connection to continuous electronic fetal monitoring and manually every hour during labour. The service also had a plan to secure capital to replace 29 CTG machines that were over 10 years old by March 2024. The new CTG machines would have capability to record maternal pulse.

The risk to delays in assembling a second theatre team if the on-call theatre team did not arrive within 30 minutes to open a 2nd emergency theatre. The service had a working group of central delivery suite and theatres staff who were updating the standard operating procedure for opening a second theatre. In November 2023 posters displaying the process for opening a second theatre for a cat 1 obstetric emergency were updated and displayed in the unit.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

Leaders monitored compliance with the Ockenden review mandatory actions to improve safety of maternity units regularly at the trust quality assurance committee that was a sub-committee of the trust board. The last Ockenden review update to the quality and outcomes committee in October 2023 showed the trust was compliant with all the 7 immediate essential actions (IEAs) but was working to fully complete and evidence the full 15 immediate essential actions. At the time of inspection 71.4% of the Ockenden IEAs have been completed, with a further 17.6% anticipated to be fully achieved within the next 3 months. There were 3 remaining amber IEAs, these are themed under centralised CTG monitoring, NICU staffing and neonatal capacity for accepting regional in-utero preterm admissions. Maternity leaders update to the quality and outcomes committee in November 2023 showed the service anticipated to be over 95% compliant with all the immediate essential actions by March 2024.

The service was working towards compliance with year 5 of the NHS Resolution maternity incentive scheme (MIS). The trust had previously demonstrated 100% compliance against the standards for the clinical negligence scheme for trusts (CNST) in years one, two, three and four, receiving the full rebate. Maternity leaders update to the quality and outcomes committee in November 2023 the service had met one of the actions, was on target to meet 7 of the actions and two actions, fully implementing Saving Babies Lives version 3 and multidisciplinary training were areas of focus.

The service had a departmental risk relating to the risk that if the trust does not achieve continuity of carer, we will not achieve CNST safety standards. At the time of inspection, the Granby Oak continuity team had been stood down for 1 month.

At the time of inspection, the service was reviewing Saving Babies Lives across the local maternity and neonatal system.

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 benchmarking and comparison.

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 submitted data to the NHS Digital maternity dashboard regularly. There were no data quality or submission issues with the upload to this dashboard.

Engagement

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

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to improve maternity services. The service held a monthly Patient Experience Group to gather feedback from service users and the MNVP was invited to and attended these meetings. However, the trust mainly used the MNVP to gather the views of local service users and they had minimal involvement in governance and co-production of maternity services.

We reviewed the minutes of the last three Patient Experience Group meetings and found feedback from service users and complaints was discussed. Actions from these meetings were monitored through an action plan that was reviewed at each meeting.

For the 2022 CQC Maternity survey the trust scored the same for 43 questions, better and somewhat better than expected for 6 questions and worse than expected for 1 question. Maternity leaders had worked to improve results to the survey through joint working with the MNVP.

The service always made available interpreting services for women and birthing people and collected data on ethnicity. Reduced fetal movement cards available in various languages including Bengali, Somali and Arabic. Staff were reminded about health inequalities and the importance of encouraging women from non-English speak backgrounds to attend with any concerns in the September 2023 women and children's patient safety newsletter.

Leaders understood the needs of the local population. The service had run induction of labour workshops in April and May 2023 to improve the induction of labour pathway.

The service was introducing a staff wellbeing app at the time of inspection and was looking for volunteers to trial the app and give feedback.

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.

Maternity

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. At the time of inspection, the service was involved in several research trials including: the Fern Study (Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy) and Stitch 2 (Emergency Cervical Cerclage to Prevent Miscarriage and Preterm Birth: a Randomised Controlled Trial).

The diversity and inclusion practice education facilitator midwife had produced ‘what’s in a name’ pronunciation stickers with people’s names spelt out phonetically to ensure staff correctly pronounced people’s names. The stickers were launched in November 2022.

Ther service had created a series of induction of labour animations to support women and birthing people to understand this process better and support informed decision making.

Outstanding practice

We found the following area of outstanding practice:

- Senior leaders had attended the ‘Black Maternity Matters’ course supporting midwives to reduce the inequitable maternity outcomes faced by Black mothers and their babies. The course was a six-month anti-racism education and training programme, examining a range of topics including unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. 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 MUST take to improve:

Maternity

- The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)
- The service must ensure medical staff have completed an appropriate level of safeguarding training to carry out their duties. Regulation 18 (2) (a)
- The service must ensure that 'red flag' midwifery staffing incidents are monitored effectively, including delays to induction of labour, in line with national guidance. Regulation 18 (1)
- The service must ensure incidents are reviewed in a timely manner. Regulation 17 (2) (b)

Action the trust SHOULD take to improve:

- The service should ensure that 'red flag' midwifery staffing incidents are monitored in line with national guidance.
- The service should ensure that hand hygiene audits are completed every month.
- The service should ensure timeliness of doctor review in maternity triage.

Maternity

- The service should ensure there is a dedicated maternity triage phone line.
- The service should complete record audits to ensure the quality of recordkeeping in maternity services.
- The service should ensure staff are aware of the location of ligature cutters.
- The service should ensure there are enough midwifery staff to provide a full range of maternity choices including use of the midwifery-led unit.
- The service should ensure emergency grab boxes are checked and ready for use.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a CQC inspectors' senior specialist, two midwifery specialist advisors and one obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.