Care Quality Commission

Royal United Hospitals Bath NHS Foundation Trust

Royal United Hospital Bath

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal United Hospital Bath

Requires Improvement 

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

We inspected the maternity service at Royal United Hospital NHS Foundation Trust 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 maternity service at the Royal United Hospital provided maternity services to the population of Bath and the surrounding areas. The service worked closely together with the Local Maternity and Neonatal Systems (LMNS). Bath is in the 20% least deprived communities nationally and 7% of women and birthing people attending maternity services were from ethnic minority communities.

The maternity service consisted of one obstetric-led unit with transformation plans in progress for an alongside midwifery-led unit, two standalone Midwifery-Led Units in Frome and Chippenham, two maternity units providing community midwifery antenatal and postnatal services.

There are around 4,500 babies born with the maternity service each year. Maternity services at the Royal Unite Hospital included a maternity assessment unit, Bath Birthing Centre (BBC), delivery suite, two maternity theatres, Mary Ward antenatal and postnatal ward.

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 the same. We rated it as Requires Improvement because:

- Our rating of Outstanding for maternity services did not change ratings for the hospital overall. We rated maternity services as Good in safe and Outstanding in well-led during this inspection.

We also inspected 2 other maternity services run by Royal United Hospitals Bath NHS Foundation Trust. Our reports are here:

Chippenham Birth Centre – https://www.cqc.org.uk/location/RD102

Frome Birth Centre - https://www.cqc.org.uk/location/RD121

How we carried out the inspection

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

Our findings

We visited the maternity day assessment unit, the delivery suite (Bath Birth Centre), maternity theatre, antenatal and postnatal wards.

We spoke with 12 midwives, 3 doctors, 3 support workers, 4 women and birthing people. We received 129 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 10 patient care records, 10 ‘observation and escalation’ charts and 4 medicines 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

Outstanding ☆ ➔➔

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

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

However:

- The service did not always have enough midwifery and medical staff to meet the increasing acuity. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- Not all staff had completed the emergency and adult basic life support training.
- The service had not provided pool evacuation training to all maternity staff.
- The service did not always follow infection control measures in all areas within the antenatal and postnatal ward.

Is the service safe?

Good ● ➔➔

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

Mandatory training

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

Staff were mostly up to date with their mandatory training. Managers monitored mandatory training compliance monthly using the perinatal quality surveillance tool, maternity and neonatal performance review meetings and specialty governance. Staff were alerted via emails when they needed to update and renew their training and escalation of training non- compliance was fed to the divisional lead for quality and safety in Family and Specialist Services.

Maternity

The maternity mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included multidisciplinary obstetric emergency skills and drills, equality and diversity, information governance, adult and children's basic life support and fetal monitoring and cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was mostly up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Training was classroom based and led by a trainer with practical workshops, scenario-based assessments, e-learning and self-assessments. Training was multidisciplinary and most learning was based around current evidence, national guidance local audit findings and risk.

Scenario-based training featured integrated team working and included simulated emergencies training, for example, emergency pool evacuation or baby abduction.

Staff received multi-professional simulated obstetric emergency training. Staff had met the 80% training compliance set by the Clinical Negligence Scheme for Trusts (CNST) for fetal monitoring, PROMPT emergency skills, drills and simulation and newborn basic life support. However, the internal trust target for compliance was 90% which not all staff had met.

For adult basic life support (BLS) the training target compliance was 90%. Data showed only 65.6% of midwives and maternity staff and 74% of medical staff had completed the training. However, the information in the data submission told us the figures given were not accurate due to the adult BLS training changing from bi-annual to yearly training. This meant not all staff had updated within the training year and the new training resource had not captured all attendance data for BLS. The resuscitation training team was currently working with the new training system to accurately record and report BLS training figures.

The service had an action plan to improve staff training compliance in adult BLS. The maternity education team had worked with the resuscitation team to add the training to the end of PROMPT training, and this had been implemented since October 2023.

The service had recently launched the high dependency unit (HDU) study day for all senior midwives as part of the trusts Ockenden actions.

Manual handling training incorporated emergency pool evacuation. Staff we spoke to had told us they had completed pool evacuation training. However, data showed midwives were 83.2% compliant and maternity staff were 79.5% which was below the trust target of 90%. Training compliance in emergency pool evacuation training was important to ensure midwives were competent in the emergency evacuation process.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia. Perinatal mental health training was included in the core competencies framework and maternity staff were 97.69% compliant.

In September 2023 the service launched 'Maternity Personalised Care and Support Planning' training and 'Maternity Anti-Racism' training. Projections provided by the service showed all maternity and medical staff would be compliant in training by February 2024.

The maternity service had a large education and retention team which included lead midwives for recruitment and retention, quality improvement and education lead for students, clinical skills facilitator, lead international midwife and lead fetal monitoring midwife. Staff and students spoke highly of the team and felt well supported.

Maternity

The education and retention team came under the quality and patient safety team and included the quality improvement and education lead midwife, retention lead midwife and three clinical skills facilitators.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed staff 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.

Training records showed 100% of maternity and medical staff had completed Level 3 safeguarding adults training.

There was 94% of midwives and just below 97% of medical staff had met the trust target for Level 3 safeguarding children training. Maternity support workers also completed level 3 Childrens Safeguarding training. Data showed 88% of maternity support workers were compliant with the training.

The service had a clear timetable for safeguarding training and included topics such as, child exploitation, perinatal mental health, female genital mutilation (FGM) and domestic violence. The training also covered how to complete effective safeguarding referrals as well as what to expect when attending strategy discussions and child protection meetings.

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

Every woman and birthing person had a risk assessment completed in the antenatal records and the service had a maternity booking antenatal care policy in place.

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

In May 2023, the maternity service completed an audit of women and birthing people’s records to identify staff compliance in asking and documenting safeguarding questions at each contact. The audit showed staff were compliant at asking safeguarding questions when appropriate to women and birthing people during initial birth assessments. There were only 19% of records showed women and birthing people had been asked safeguarding questions during each maternity contact. However, the audit highlighted that 96% of records showed women and birthing people had been asked about domestic violence at least once during their pregnancy.

Following on from the audit the service put in place recommendations. These were to remind midwives of the importance in seeing women or birthing people on their own during appointments at least twice during their pregnancy and to reinforce and discuss during safeguarding supervision the importance of domestic abuse enquiry. The service had plans in place to complete a re-audit in February 2024.

Staff could access a specific electronic system to identify any safeguarding risks linked to a woman or birthing person and staff could access the safeguarding team when they needed further support or guidance.

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

The Lotus continuity team worked with all women and birthing people who had complex social factors. For example, some of the criteria for referrals included current drug or alcohol abuse, current or recent domestic violence and current social care involvement.

The Lotus team had midwives based in each geographical area covered by the trust. Women and birthing people were triaged and if they met one of the referral criteria then they would be booked by a Lotus team midwife. The team provided continuity and personalised care.

The safeguarding team had bimonthly maternity meetings which fed into the vulnerable people children's assurance committee. Staff felt the safeguarding team were visible and supportive. Local safeguarding teams had recently extended the age of vulnerable and young women and birthing people to under 25 to increase support.

Staff within Bath Birthing Centre (BBC) received 1 to 1 supervision quarterly as well as when staff required further safeguarding supervision.

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

Cleanliness, infection control and hygiene

The service did not always manage infection risks well. Staff did not always use equipment and control measures to protect women and birthing people, themselves, and others from infection. The equipment and the premises were not always visibly clean.

Staff did not always use equipment and control measures to protect women and birthing people, themselves, and others from infection.

Following our inspection and a review of further trust data provided we saw midwifery staff had completed and were compliant with the trust target for infection, prevention and control (IPC) training.

Maternity

Data received from the service showed between June 2022 to August 2023, Mary Ward scored poorly in environmental audits. Following poor audit scores, the service put in monthly action plans, completed by the ward matron to address and improve infection risk. Audits completed in September 2023 and November 2023 showed all environmental areas and hand hygiene assessments had improved, and all areas scored 100%.

During the inspection we saw maternity areas were uncluttered and tidy. However, on Mary Ward there was dust observed on some curtain rails and equipment.

Each area had their own specific cleaners who cleaned throughout the day. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

Staff cleaned equipment after contact with women and we saw 'I am clean' stickers used to identify when equipment was cleaned. Therefore, staff using equipment could be assured the equipment had been cleaned prior to being used.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed hand hygiene audits alongside environmental. Data showed from August 2023 to November 2023 all staff were 100% compliant in hand hygiene within the bath birthing centre.

Mary Ward was only 73% hand hygiene compliant in August 2023, 100% compliant in September 2023 and October 2023 and 93% compliant in November 2023.

Staff had access to infection control policies and compliance audits was reported on the infection control divisional report. Following scores of low hand hygiene and low environmental scores the service put an action plan in place and data showed an improvement in compliance.

Environment and equipment

The current design, maintenance and use of facilities and premises were not all suitable in providing safe care and treatment to women and birthing people. The service had enough equipment and staff were trained to use them. Staff managed clinical waste well.

The design of the environment did not always meet the needs of the maternity service. The maternity unit was situated at one end of the hospital with its own entrance and parking.

The service flowed from the maternity day assessment unit (DAU) through to the antenatal clinic, and had direct access to the delivery suite, Bath Birthing Centre (BBC). Mary Ward containing both antenatal and postnatal women and birthing people was situated on the floor above.

The current lay out of the day assessment unit did not meet the needs of women and birthing people and there were challenges for timely assessment of risk for unscheduled care. Currently care was provided in two assessment rooms and a curtained bay area. Appointments were provided only for scheduled care as there was a lack of space to accommodate the unscheduled and ongoing care alongside scheduled care.

Women and birthing people attending the unit accessed the service through the day assessment unit (DAU). The DAU currently provided care in a 3 bedded assessment unit with a separate waiting area. Maternity staff and senior leaders told the inspection team the current DAU space was not suitable to provide scheduled and unscheduled care because

due to the small size of the unit. The DAU was currently undergoing a complete re-design to improve patient and workforce experience. The plan was to increase the size of the environment. The triage area was to remain within the Bath Birthing Centre but to be redesigned to increase capacity. The scheduled care was planned to be moved to the newly developed day assessment unit next to Mary ward.

Antenatal and postnatal care was situated within Mary Ward. The ward had 6 separate side rooms for antenatal care and 2 separate side rooms for postnatal care. There were two bays used in the postnatal area for transitional care babies. Inductions of labour were mostly started on Mary ward and transferred to Bath birthing centre if required.

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. Staff told us there were facilities for partners staying on the ward to have a shower and the team had recently secured funding for recliner chairs for 12 postnatal bed spaces.

The service had a planned maintenance schedule, which included a 6 monthly engineer visit to each clinical area to carry out maintenance on devices due for service. The service sent a list prior to the scheduled visit so all devices were made available.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. The maternity unit was fully secure with a monitored entry and exit system and the service had completed baby abduction drills.

All equipment and store cupboards during the inspection were visibly clean, tidy, and uncluttered. A fridge specifically for infant milk storage was kept in a locked room which stored medicines and dressings. The name, hospital number, date and time expressed were written clearly on all labels.

The milk fridges were checked daily to ensure they were maintained at the correct temperature for safe storage. The milk kitchen was open to allow access to sterilising facilities, although all fridges containing infant milked were locked.

The service had a purposed built and designed bereavement suite to help women and birthing people and their families. The suite provided an area of privacy away from the maternity area.

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, resuscitaires in each birth room and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. Staff mostly carried out daily safety checks of specialist equipment. We found there were gaps in staff checking the neonatal resuscitation trolley and the adult resuscitation trolley in Mary Ward.

Documentation in all other maternity areas the adult resuscitation equipment and baby resuscitaires throughout the maternity department were checked daily.

Staff told us there had been previous complaints from women and birthing people that it was too uncomfortable to kneel in the Bath birthing centre rooms during labour. Service leaders responded to this feedback and purchased floor mats and birthing balls.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

Maternity

The service used a maternity specific ligature risk assessment. The risk assessment identified potential women and birthing people at an increased risk of psychosis and the risk of harm towards themselves or their baby. The risk assessment was completed with the mental health liaison team. All women and birthing people at high risk of self-harm had a mental health assessment completed including potential triggers and relapse indicators.

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

Assessing and responding to risk

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

Staff risk assessed women and birthing people at their booking appointment and used the 6 elements of the 'Saving Babies Lives Care Bundle Version 3' (SBLv3) which were: reducing smoking in pregnancy, risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction, raising awareness about fetal movements, effective monitoring of fetal monitoring during labour, reducing preterm birth and management of pre-existing diabetes.

The service had issues with data capturing due to a mix of electronic and paper records. The maternity dashboard was only able to capture compliance of carbon monoxide (CO) readings and smoking status on the electronic records. The service was monitoring the issue and the CO readings and smoking status formed part of the audit programme to ensure data capture of both electronic and paper records. From August 2023 to October 2023 the service met the 80% minimum standard for CO readings at booking and at 36 weeks gestation.

Leaders tailored services to meet the need of the local community. The service implemented a midwife-led contraception service for women with complex social needs.

A midwife-led ultrasound clinic was established with dedicated midwife sonographers working alongside obstetric specialist teams to reduce the risk to women and birthing people with complex pregnancies.

Staff completed risk assessments for women and birthing people on arrival. They used a recognised tool, and reviewed this regularly, including after any incidents.

Maternity staff worked with the implementation team to monitor and audit risk to women and birthing people attending the unit for unscheduled care.

To minimise risk the implementation team developed a standardised triage SBAR (situational, background, assessment and recommendation) tool in November 2023. The SBAR included a triage tool, RAG (red, amber and green) rated expectations for ongoing care and escalation guidance if the triage and ongoing care times were not met. Auditing of the tool was due to start in December 2023 and would focus on triage waiting times, compliance to RAG rated status for ongoing care and medical review. We were told the results from the audit would be used to support implementation of the prioritisation tool.

The day assessment unit currently incorporated the assessment of unscheduled care and there was no separate telephone triage line. The service had introduced a new triage standard operating procedure which included the triage SBAR, and RAG rated system. The service had 2 clear pathways for DAU and triage.

Maternity

The current telephone line was staffed by midwives but there was no dedicated telephone line for triage. All women and birthing people attending the day assessment or calling the telephone line were assessed using the SBAR tool. Women and birthing people attending for unscheduled care who were high risk were transferred straight to Bath birthing centre where there was a dedicated assessment bay.

The service had completed a telephone DAU/triage audit in June 2023 to review telephone line activity across scheduled and unscheduled care to collate data to support putting in place of a dedicated telephone line following the redevelopment of the service.

An emergency call bell system was linked from DAU to Bath birthing centre so support could be accessed directly. The DAU and maternity triage were both on the maternity risk register.

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. The service completed a short data capture audit of 3 nights in November 2023 to review unscheduled care activity at night within the DAU. The results showed out of 32 women and birthing people that had attended the day assessment unit over the 3 days for initial triage, 88% were seen within 15 minutes, 6% were seen between 15 – 30 minutes and 6% above 30 minutes.

The short data capture audit aimed to establish triage and medical review waiting times to assess the initial compliance to the RAG rated SBAR tool. The service was continuing to complete monthly auditing of timeframes for unscheduled care.

The triage audit proposal included the auditing of triage waiting times, compliance to RAG-rated status for ongoing care and medical review, modified early warning score (MEWS) compliance and telephone triage electronic capture compliance. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

The service was an early adopter/pilot site for the national Maternal Early Warning Score (MEWS) charts to identify women and birthing people at risk of deterioration and escalated them appropriately.

MEWS charts were used for each woman and birthing person. The use of MEWS is important because it improves the recognition of and reduces the delay in treatment of Sepsis if a deviation from the normal occurs.

The service completed audits on the use of MEWS charts following birth and in the postnatal period on the Bath birthing centre. The audit was completed as part of a wider audit on sepsis and used to identify whether maternity staff were using MEWS charts during each post-natal contact on Bath Birth Centre. The audit identified that all MEWS had been completed correctly and staff were acting on warning triggers.

The trust monitored the vital sign for babies using a newborn early warning trigger and track (NEWTT). The service completed auditing of NEWTT. From August 2023 to October 2023 there was 100% compliance in patient records.

Staff shared key information to keep women safe when handing over their care to others. There was a multidisciplinary safety huddle including, anaesthetic team, consultants, medical staff, and labour ward coordinator took place daily on the Bath birth centre (BBC).

The service had a twice daily ward round on Bath birthing centre as per national guidance and there was comprehensive consultant presence on-site.

Maternity

Staff we spoke to knew how to escalate and were aware of key risks. Staff described a positive safety culture and were encouraged to attend the weekly risk meeting.

Staff knew about and dealt with any specific risk issues. 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 who were having continuous cardiotocograph (CTG). Cardiotocography is a medical test to monitor the fetal heartbeat and contractions of the uterus, and provides a continuous recording or the baby's heartbeat.

The team used a buddy system approach to provide a holistic review for fresh eyes. This was completed hourly when CTG monitoring was used and at least 4 hourly when intermittent auscultation was used unless there was a trigger to provide a holistic review earlier. Intermittent auscultation is the technique of listening to and counting the fetal heart rate for short periods during active labour.

A cardiotocography monitoring in labour audit was completed in May 2023, which showed an overall compliance of 77% against the 27 standards audited. Areas of improvement/low compliance related to documentations on date of delivery, pulse rate at start of monitoring, systematic assessment of condition, signature of professionals and mode of birth. Hourly fresh eyes audit showed 84% compliance in May 2023.

The CTG audit was revised to include further data in September 2023, and this showed the compliance had improved with 95% compliance in September 2023, 85% compliance in October 2023, and 90% compliance in November 2023.

Shift changes and handovers in other maternity areas included all necessary key information to keep women and birthing people and babies safe. Each area of the maternity unit had a team handover twice a day to ensure all staff were up to date with key information.

The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each patient. Between April 2023 to July 2023 an audit was completed to highlight the SBAR being used in handover between midwives during intrapartum care. The audit found handover between midwifery staff at the end of each shift was clear, with 100% of records showing the SBAR sticker had been completed.

The service had reviewed and mitigated the risk of reviewing and monitoring women for unscheduled visits with urgent pregnancy concerns within the day assessment unit (DAU).

Delays in induction of labour (IOL) was added to the maternity risk register due to the capacity of the unit and the number of women and birthing people attending the service for IOL's. The service had an IOL care pathway and a standard operating procedure for the management of women for IOL's.

There was a separate induction bay for IOL and daily prioritisation and management of women and birthing people attending for IOL was completed by the on call obstetric consultant.

Prioritisation was based upon the clinical need of the IOL list and daily telephone calls to women who were scheduled for IOL by the flow midwife to update them on the service and any changes. This included an opportunity to discuss with the woman and birthing person any changes to clinical condition to determine prioritisation.

There was continued work with the local maternity and neonatal system's (LMNS) working party for IOL's to look at how they were prioritised. The working party was responsible for creating a framework to explore a RAG rated system to monitor the risks and delays.

Maternity

Maternity Monthly internal performance reports and quarterly reports highlighted whether the service was maintaining safety standards and completed a RAG rating. Safety standards included 1:1 care in labour, supernumerary labour ward coordinator and midwife to birth ratio. The quality report for the service identified that between May 2023 to October 2023 there had been 1 occasion where 1:1 care in labour was not maintained and there were 9 incidences where the supernumerary labour ward coordinator was not maintained, including 5 times when this occurred in October 2023. During this period staff told us the contributing factor was staffing, with a 7.41 wholetime equivalent midwifery staffing gap during this period. The service had produced a business case for a workforce plan which was presented to the board to increase the midwifery establishment.

Staff caring for women and pregnant people during childbirth used a partogram to plot progress during labour and to identify any deviations from normal childbirth progress. Audits showed that the service were 100% compliant.

A review of incident submissions and benchmarking via the national dashboard identified that the post-partum haemorrhage (PPH) rates for RUH were higher than the national average. The quality and improvement lead midwife led a review for learning and improvement to identify the themes or trends to identify the causes of high PPH rates. There was 5 findings and recommendations following the review and one recommendation around identifying women at potential risk of PPH. Clinical outcomes of PPH were monitored monthly.

Data reviewed showed that since commencement of the actions by the service there was an improvement in PPH rates and rates were below the national average from between September 2023 to December 2023.

The service followed the ‘Five Steps to Safer Surgery’ World Health Organisation (WHO) checklist which included a sign in, time out and sign out checks. Patients had a copy of the 'Five Steps to Safer Surgery' WHO checklist in their notes. The service was 100% compliant with the WHO checklist between August 2023 to October 2023.

The service monitored maternal and baby readmission rates. The national maternal sepsis action tool was used by the trust and applied to all women and birthing people who were pregnant. Women and birthing people who were up to 6 weeks postpartum following the birth of baby who had a suspected infection or clinical observations outside of normal limits. Readmission rates were in line with the national average.

Unwell women and birthing people who had been readmitted to the postnatal ward were reviewed daily by the medical team and all transitional care babies were reviewed daily by the paediatrician. The service had a twice daily ward round on the delivery suite as per national guidance and there was consultant presence on-site.

The service provided a 7-day service for screening programmes such as antenatal screening, hearing, newborn and infant physical examination (NIPE) and the newborn blood spot test. The NIPE test is a full physical examination of newborn babies within 72 hours after delivery. All women and birthing people who did not attend screening or antenatal appointments were contacted and followed up.

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. Ligature risk assessments had been completed for each maternity area.

Maternal mental health clinics were in the process of being implemented by the service. The trust had been identified as a fast follower site and the service will provide support to women with trauma related to birth and pregnancy loss.

Maternity

Staff shared key information to keep women and birthing people safe when handing over their care to others and staff used a situational background assessment recommendation (SBAR).

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. However, 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.

Managers accurately calculated and reviewed the number and grade midwives and maternity support workers needed for each shift in accordance with national guidance.

Leaders collected trust-wide data on staffing across all sites to complete a maternity safe staffing workforce review using a recognised national tool in 2022 and the final report was received in April 2023. The results showed a shortfall of 11.93 whole-time equivalent band 3 to 8 midwives from the current funded establishment. The report highlighted an increase in the need for maternity services and identified the need to increase clinical and non-clinical roles across the service. As a result of this, the midwife to birth ratio in July 2023 changed from 1:28 to 1:24.

In October 2023, there was a midwifery workforce gap of 7.41 whole time equivalent (WTE) which included maternity leave. The service reported the top contributing factors were vacancy rates, maternity leave and challenges in recruiting midwives. During October 2023, the service met acuity 69% of the time, meaning there was not always enough staff to meet the needs of women and birthing people and to provide safe care. Following this, the service took action by introducing a weekly roster report to review staffing numbers alongside high acuity.

There had been several initiatives used to recruit staff and the service had recruited registered nurses to support midwifery staff on Mary ward. There were career progression opportunities for maternity support workers and maternity care assistants. The service had introduced specialist bank pay rates for maternity staff, this included midwives, maternity support workers and maternity care assistants.

There had been a large reduction in band 5 staff turnover. The retention midwife had worked hard to complete an improved preceptorship period and further support for newly qualified midwives, this included a new welcome and preceptorship pack. The induction for each new starter incorporated all required training and orientation within the first 6 to 8 weeks of starting. New staff received a 'goody bag' with a health and wellbeing booklet as well as a welcome postcard introducing the new staff member to their team.

Band 5 midwives were linked to a professional midwifery advocate to identify any unmet needs and for continued support. This improved programme and further support offered meant the service had a 100% retention rate of band 5 midwives from May 2022.

Staff told us they were proud of the increased numbers of band 5 midwives and the support offered. However, the service had experienced high acuity levels and high shortness of staff between August 2023 to October 2023, which coincided with a high number of band 5 midwives being orientated into the maternity service at the same time.

The service submitted a Maternity and Obstetrics Workforce Report' in October 2023 requesting approval for ongoing investment into the Maternity and Obstetrics Investment Business case within the trust. The report highlighted the ongoing pressures within the maternity service due to rising acuity and complexity within maternity, alongside unsustainable mitigations to avoid staff burnout and clinical risk.

Maternity

Maternity leaders utilised the redeployment of specialist midwives and on call staff to the areas with high risk for example, the Bath birthing centre (BBC). This meant over the last quarter the service had used the clinical skills facilitator team to support the service and work clinically for 70% of their shifts. However, the redeployment of specialist midwives did not always support the impact of staffing levels within Mary Ward. The service redeployment was not a sustainable model of care and service leaders had requested an investment into maternity staffing of 32.95 whole time equivalent. Following submission of the 'Maternity and Obstetrics Workforce Report' in October 2023, the trust had agreed to fund the request and the service were currently in the process of recruiting.

There was a supernumerary shift co-ordinator on duty 24 hours a day, 7 days a week, who had oversight of the staffing, acuity, and capacity. When staffing was less than the required number the service followed the maternity escalation policy and redeployed specialist midwives and Band 7 managers and above to work clinically. The policy identified that during the escalation period, redeployed staff would relocate to ensure 1:1 care in labour and the dedicated supernumerary labour ward co-ordinator roles were maintained.

Staffing fed into the trust wide acuity tool for the maternity service. Information provided by the service showed the service reported '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.

From May 2023 to October 2023 the service reported there had been only one incidence of the service not meeting 1:1 care in labour. This was in October 2023, when the service was reported to be at high levels of acuity. The service did not meet the target of 1:27 midwife to birth ratio for June, July and October 2023 and there were 9 times over the 6 months audit time frame where there was a period where the labour ward coordinator was not supernumerary. A review of the quality reports from May to July 2023 and August to October 2023 showed the service did not meet the targets and this was due to high acuity and pressures on staffing.

The maternity risk register identified obstetrics workforce risk and maternity workforce was high on the maternity risk register.

From August 2023, the service had seen an increase in delays for induction of labour (IOL). Data showed in October 2023 the number of red flags recorded was high due to high levels of acuity to the service with a high number of red flags caused due to delays with women and birthing people undergoing an IOL. The increase to delays in IOL was escalated to the Local Maternity and Neonatal Systems (LMNS) and the regional head of midwifery/director of midwifery support group to escalate and request support from other local trusts.

Delays in inductions of labour was added to the maternity risk register and an action plan was formulated to reduce the risk and impact on the service. Flow midwives were in post to communicate and liaise with women and birthing people. This was carried out using a live electronic form online to make sure all records were up to date for the location and the number of women and birthing people on the IOL list. This allowed a better balance of IOL's across the 3 trusts within the LMNS.

Staff we spoke to told us that all specialist midwives and managers were very supportive and would work clinically to support the team. Specialist midwives were based within Mary Ward where staff could access them easily for support and advice when required.

Maternity

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.

The day assessment unit (DAU) was currently staffed with two band 6 midwives during the day and at night. The unit had admin support during the day. The telephone line was not specific to triage. However, it was 24 hours and was staffed by a midwife. Staffing for scheduled and unscheduled care was due to change to accommodate the extension to the service. Proposed staffing was 2 midwives situated within triage 24 hours, 7 days a week and for 1 midwife based within the day assessment unit from 8am to 8pm. An additional midwife would answer all triage calls for maternity and be based in a separate room. This staffing proposal was agreed by the board in October 2023 and the service had already appointed staff and training had started.

Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and development through yearly, constructive appraisals of their work. The education and retention team supported midwives. The data provided showed the service had not met the trust target rate for appraisal of 90%. In November 2023, the maternity service was 86% compliant and there was a plan to complete all staff appraisals by December 2023.

The induction progress checklist for all new starters was clear and detailed. All Band 5's and 6 midwives completed a sign off sheet which included new staff completing 3 reflective pieces or writing, study and specialist sign off. They also required a competency sign off from three Band 7 midwives.

Managers made sure staff received any specialist training for their role. There were several specialist midwife roles within the service. Staff told us the specialist midwives were visible across the unit and were supportive and responsive.

There was a variety of specialist midwives employed within the services. These were antenatal screening midwife, newborn screening lead, diabetes specialist midwife, infant feeding lead midwife, health in pregnancy lead midwife, patient safety midwife, clinical audit midwife, quality improvement and education lead midwife, retention lead midwife, patient experience lead, bereavement lead midwife, safeguarding lead midwife, digital lead midwife, pelvic health lead midwife, inclusion midwife, ocean (perinatal trauma loss and support) midwife.

The service had employed an inclusion midwife to support the work the service was doing within health inequalities.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience to keep women 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 did not always have enough medical staff to keep women and birthing people and babies safe. Medical staff worked within both obstetrics and gynaecology services. A review of the maternity risk register showed medical staffing was currently on the maternity risk register as a 'high' risk.

The obstetric cover to Day Assessment Unit (DAU) was provided by the on-call obstetric team consisting of doctors who were either an obstetric consultant, registrar and senior house officer. Following the transformation of DAU, the service had no immediate plan to change obstetric medical cover.

Information shared by the trust highlighted the numbers of medical staffing for RUH had not increased within the last 8 years, therefore, the number of medical staff did not meet the increased number of women and birthing people using the service. Data reviewed showed that out of 25 trusts with a similar number of births, the RUH had the lowest number of consultants.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The RUH had 13 consultants in Maternity and Gynaecology, with 98 hours of onsite consultant presence over a 7-day working week on the Bath Birthing Centre (BBC). There was 24-hour obstetric cover provided by the onsite registrar specialist trainees and 98 hours of onsite consultant presence inclusive of morning and evening multidisciplinary ward rounds.

The service always had a consultant on call during evenings and weekends. On-call obstetric cover was between 5pm to 8.30am. Weekend cover was provided by a registrar with obstetric consultant on site cover provided a minimum of 9 hours a day.

The service did not currently have any obstetric locum posts and had not used locum obstetric cover within the last year. Shortfalls in medical staffing were covered internally by current obstetricians or from clinicians within the deanery who had worked for the trust and had completed a formal induction for the trust.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The current obstetric consultant workforce appraisal compliance was 77%, however, it was expected that appraisal compliance would meet the target rate of 90% before the end of the appraisal period. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The service used both handwritten records and electronic records. The unit currently used handwritten and electronic patient records, this meant there was often duplication of work. All intrapartum care was recorded onto handheld records and then retrospectively put onto the woman or birthing person's electronic records.

The service was working alongside local trusts to use an electronic record system to share information. The digital midwife was part of a national group for digital midwives who met monthly online to support each other and share information. Information was shared within the maternity digital committee.

Staff felt confident and competent to use electronic records. However, staff and senior leaders told us there were developments required to the electronic system to allow for better auditing of records and a clearer overview of risks.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 10 paper records and found records were clear and complete.

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

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

Maternity

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines administration charts for medicines during admission were completed in women and birthing people's hand-held records. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

All newly qualified staff completed a medicines management workbook following their attendance. Midwives undergoing their preceptorship were required to provide evidence all workbooks were completed to progress to a Band 6 position.

Medicine Management training for medical staff was facilitated face to face with the lead pharmacist as part of the induction to the organisation. The target for medicines management compliance was 90%. Compliance rates in November 2023 were 97% for midwives and 93% compliance for doctors and medical staff.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in a locked cabinet and could only be accessed by authorised staff.

Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was a variation.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff followed trust guidelines on how to identify and report incidents. The service used an online incident reporting system and updated the national Strategic Executive Information System (STEIS) if a serious incident was declared.

Managers reviewed the Maternity and Newborn Safety Investigations Programme (MNSI) and any serious incidents. Incidents were reviewed on a regular basis so they could identify potential immediate actions and learn from incidents. There had been 4 MNSI cases from May 2023 to November 2023 and there were ongoing investigations for 3 of those cases.

The trust had a process for managing and reviewing incidents and near misses. Maternity incidents were reviewed weekly and reported monthly to maternity and neonatal specialty governance, divisional governance and by the maternity safety champions, trust board and bi-monthly by the quality governance committee.

The service had 1 open serious incident over 60 days. The investigation report was due to be reviewed at the same time of the inspection and there had been an agreed extension date with the local maternity and neonatal systems.

Maternity

The trust's maternity and neonatal transformation strategy identified a safety culture to improve the experience and care outcomes for women, birthing people and babies. The service set out 3 objectives, which were developing a positive safety culture, learning and improving and support and oversight.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The service had a low and no harm incident management flowchart. Incidents were managed by the quality and patient safety team. Incidents outside of those outlined within the flowchart were managed by the clinical area manager with the quality and patient safety team supporting with oversight. Incidents which formed part of a wider thematic analysis of further systematic learning were shared with the maternity and neonatal governance for shared learning.

For example, following a high incidence of post-partum haemorrhage (PPH) and rates higher than the national average, the service had reviewed 6 months of PPH data to identify trends and themes as to why there had been an increase in data.

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.

The trust was transitioning the review of incidents to the patient safety incident response framework (PSIRF) to review and manage incidents this meant low, and no harm incidents formed part of a wider theme and trend analysis including national benchmarking. We reviewed incidents reported in the 3 months before inspection and we found incidents relating to PPH and 3rd and 4th degree tears were reported to be low or no harm. However, the service had full oversight over low and no harm incidents with the patient safety team completing deep dives into all incidents with evidence of learning through incidents. We saw this evidenced through maternity governance minutes.

Managers reviewed incidents potentially related to health inequalities. Incidents relating to health inequalities were referred to the health inequalities working party within the service. For example, following a review of PPH incidents the maternity service identified that women of an Asian background were more likely at risk of PPH.

All perinatal deaths were reported using the perinatal mortality review tool (PMRT) and the service met monthly for Perinatal Mortality Review Meetings to discuss specific cases.

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

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

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?

Outstanding ☆ ➔➔

Maternity

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

Leadership

Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond and plans to manage them which were shared with staff. Leaders had the skills and abilities to run the service.

There was a clearly defined management and leadership structure with the director of midwifery, clinical director, divisional director and divisional director of operations leading the maternity service. The director of midwifery had been in post for 13 months and was well respected by all staff we spoke too.

The trust 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 director of midwifery was supported by the deputy director of midwifery and the neonatal nurse consultant.

The service leaders told us they had good support and direct access to the trust board, and this worked very well. Staff told us the trust board took issues raised with them seriously and this were taken on board to drive improvement. We saw from the minutes of board meetings that the trust board had oversight of the maternity service performance.

Specialist midwives and teams reported to the Band 8A leads, who were line managed by the deputy director of midwifery.

Leaders supported staff to develop their skills and take on more senior roles and there were several specialist midwifery roles.

Staff spoke highly of the work being completed by the quality improvement and patient safety lead and the education and retention team. Although the service had recruited into a number of specialities, we were told by staff this did not stop the team supporting staff and working clinically if required. Specialty midwives were based in an office next to the reception desk on Mary Ward and staff told us they liked this and were able to gain advice or guidance whenever they needed it.

Senior leaders were visible and approachable in the service for women, birthing people and staff. Staff Leaders were well respected by the maternity team and staff told us leaders were responsive to staff.

The service was supported by maternity safety champions and a non-executive director. The non-executive director (NED) was there to provide an objective and external challenge. Their remit was to understand the current outcomes of the service, review services, current maternity risks, and report to board.

The maternity safety board champions visited the maternity unit and liaised with outside representatives such as the maternity neonatal voices partnership (MNVP) group to review services, monitor risk and provide the board with a report of maternity services.

Maternity

Leaders were visible and approachable in the service for women and birthing people and staff and were well respected. Maternity safety champions met monthly. All meetings were attended by the operational safety champions team (maternity, neonatal and obstetric) in addition to the maternity and neonatal safety and quality lead.

Themes of meetings covered staff workforce, perinatal mortality review (PMRT), incidents, responsiveness of the team, saving babies live care bundle. The team also discussed themes of low or no harm.

Vision and Strategy

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. Staff could explain the vision and what it meant for women and birthing people and babies.

The service co-designed the Maternity and Neonatal transformation Strategy 2023 to 2028 with staff, service users and the maternity and neonatal voices partnership (MNVP). The paper set out the vision for maternity and neonatal services and a pathway to delivering care. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and revised the vision and strategy to include these recommendations.

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

The strategy aligned with national objectives, which included 6 key themes; these were: workforce, equity of care, improving quality and safety, increasing the use of digital, personalised care and creating buildings that are fit for the future and providing a service that is personalised. Underpinning the 6 themes were leadership, communication and listening, and service user involvement.

The service recognised maternity workforce retention was key to delivering the vision and goals and there was a retention and recruitment strategy in place which had a clear focus on staff wellbeing. There was a focus on staff's mental health and well-being and the service had increased the number of professional midwifery advocates to increase the capacity for supporting staff.

The Maternity and Obstetrics workforce report detailed the request for ongoing investment in maternity and obstetric services to meet the increasing demand of the service.

The service had also started to roll out inclusion and diversity training for all staff, improved preceptorship induction for new midwives as well as pathways into midwifery for maternity support workers.

Culture

There were high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. Staff felt respected, supported, and valued. They were focused on the needs of women 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 women and birthing people, their families and staff could raise concerns without fear.

Maternity

Staff felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Staff told us there had been a huge change of the culture within the maternity service over the last 13 months. Staff were highly positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. For example, several staff spoke positively about their line managers and the maternity leadership team and told us they listened and escalate staff concerns immediately to the maternity safety champions and trust board.

Culture and leadership were 1 of 4 themes within the delivery plan for maternity services to developing a positive safety culture as one of the objectives to the delivery plan. To achieve a positive safety culture the service recognised maternity leads required time to access training and development, engage with stakeholders such as patients, external health services and the maternity and neonatal voice partnership (MNVP).

Staff were focused on the needs of women and birthing people receiving care. Staff and leaders were passionate about their role and 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.

The service worked closely and positively alongside other maternity leaders from neighbouring trusts as part of a perinatal culture and leadership programme for maternity services. The programme was a 3 staged approach and included completing a culture survey within the organisation focusing on how you lead change.

The staff survey 2022 results showed the service had a positive response, and there had been an improvement in all areas of the maternity service, with the service scoring higher than in previous years in areas such as, 'we are compassionate and inclusive', 'we each have a voice that counts', 'we are a team' and 'staff engagement'. The areas where the service scored lower were 'we are safe and healthy', 'we work flexibly' and 'morale'.

An analysis of the staff survey was completed in 2023 and this showed there had been an improvement on the staff survey results.

There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. It was common practice for the leadership team to offer listening events for staff. Staff told us there was equal opportunity to progress in their career. We saw examples of staff who had progressed to a leadership role over the years from junior staff.

Recruitment and retention had improved including 100% retention for all new Band 5 starters.

Staff told us they were encouraged to talk about their experiences at professional development days. The service had 8 trained mental health first aiders to offer support. The clinical psychologist from within the local neonatal unit supported staff debriefs following events.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture which placed people's 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**.**

Maternity

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

Maternity services worked with the maternity neonatal voice partnership (MNVP) to improve communication with ethnic minority groups and the LGBT+ community within the service.

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 started a health inequality working group which reported into the Maternity Governance Group, providing monthly information on infant feeding updates on health inequalities data. In July 2023 the service introduced an inclusion midwife to speak to women to gain their feedback on their birth experiences and a performance audit coordinator to improve data quality.

The service had recently secured 10 spaces for 'Black Maternity Matters' training in June 2023 and the service had rolled out cultural competencies for all staff to complete.

Alongside the MNVP there was a clear focus on improving the experience and care of women and birthing people from different cultures. This included capturing data on women and birthing people within ethnic minorities who were late at booking their pregnancy, as well as looking at the implications and support with women from ethnic groups for infant feeding and breast feeding.

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. The service had no formal complaints between August 2023 to October 2023.

The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

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

The maternity service worked with the perinatal mental health team to set up a specific group called the Ocean Birth Trauma and Loss Service. The group was made up of specialist midwives and psychological therapists who offered psychological assessments, support, and therapy to women and birthing people who experienced worry, anxiety or fear associated with having a baby.

Governance

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. Governance arrangements were proactively reviewed and reflected best practice. 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 was a clearly defined governance structure that detailed the governance oversight and accountability from the service level to the trust board level. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Governance arrangements were proactively reviewed and reflected best practice.

Leaders operated effective governance processes, throughout the service and with partner organisations. Governance and performance management arrangements were proactively reviewed and reflected best practice. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The maternity service told us the board of directors were interested, engaged, and committed to the maternity agenda and we saw evidence of board meeting minutes which showed this. Minutes showed the board were clear on maternity priorities such as national drivers and the director of midwifery and clinical obstetric lead presented an educational seminar on the national and local maternity safety agenda.

The service leaders assessed, monitored, and improved the service through effective audits and mitigating risks. There were two patient safety midwives who worked alongside the quality and safety lead for the maternity service.

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

The service had a clear governance risk management structure with specialist midwives and maternity safety champions feeding into meetings for quality and safety.

The maternity and neonatal speciality governance team fed into the divisional governance board alongside the divisional board. Divisional governance reported to the trust quality and patient safety group, through to the quality governance committee and up to the board of directors. The maternity safety champions also fed into the board of directors.

The trust had maternity safety champions work with maternity senior leaders to support The Maternity and Neonatal Transformation Strategy. This was to develop partnerships and a clear structure for sharing risks from the ward through to board. They supported the implementation of learning from national and local initiatives and provided feedback to the board on key priorities for maternal and neonatal safety.

A clear audit plan for 2023 – 2024 had been developed and this included audits which were national audit drivers for example, Saving Babies Lives, Ockenden and Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE). MBRRACE was a national collaborative programme of work into maternal, still birth and neonatal deaths. For example, the audit plan included the auditing of the National Perinatal Mortality review tool, identification and recording of risk status for fetal growth restriction.

Maternity

The maternity services Clinical Governance Meeting met monthly, and information discussed was fed into the divisional governance report. We reviewed the monthly meeting minutes and saw the service had an oversight into several areas including serious incidents, clinical care outcomes, training needs and clinical effectiveness.

Staff followed policies to plan and deliver care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies for updates.

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.

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. Staff were actively engaged in activities to monitor and improve quality and outcomes. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. The service completed a Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 4 declaration of compliance to the board of directors in January 2023.

The report identified that the service had achieved all 10 safety actions as part of CNST. The divisional assurance panel was led by the director of midwifery and clinical lead for obstetrics, and they reported the service was able to demonstrate the achievement of meeting the safety actions. For example, the perinatal mortality review tool (PMRT) was used to review perinatal deaths. The service had established transitional care pathways and ATAIN (avoiding term admissions into neonatal care).

All Maternity and Newborn Safety investigations programme (MNSI) cases were investigated internally by the trust as well as independently by the MNSI. Serious incidents and MNSI cases went through specific criteria process. This was to ensure there were no immediate actions needed to be taken.

The trust shared key quality issues, risks and concerns related to or affecting maternity care and services with the Local Maternity and Neonatal Systems (LMNS) reporting template. The service shared reports on data quality, audits and dashboards of national systems.

Incidents and events in maternity and neonatal services were reported on the electronic reporting systems. The service had a process for managing and reviewing low or no harm incident management. The maternity and neonatal quality and patient safety team reviewed specific incidents. An example, of the specific incidents reviewed by the team were unexpected admissions to neonatal intensive care unit (NICU), postpartum haemorrhage above 1500mls, any moderate harm or above and unexpected deaths. All other incidents were allocated to the appropriate clinical manager.

Maternity

Serious incident review meetings were held weekly and were multidisciplinary attended. The service had a 'Patient Safety Tracker' kept by Maternity, which documented the attendees at each multidisciplinary meeting. If required, the service held further meetings to discuss serious incidents to make sure all initial review of incidents were completed within the designated timeframe. A review of all care undertaken, and actions taken were documented within each individual incident reported.

Managers and staff carried out a comprehensive programme of repeated local and national audits to check improvement over time. They audited performance and identified where improvements were needed. Managers shared and made sure staff understood information from the audits. A copy of the audit plan for 2023 to 2024 showed there were currently 41 audits in progress. The service 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. The service had a system's support tool in place to monitor and review via red, amber and green (RAG) rated system as to whether the service was aligning to the Ockenden review and the services delivery plan.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. The 3 main risks identified on the maternity service risk register were midwifery staffing vacancies, obstetrics and gynaecology workforce investment and the maternity information system support.

The day assessment unit was listed on the risk register due to the current environment not being fit for purpose.

The service monitored risk and completed quarterly perinatal quality surveillance reports to identify where the service was not meeting the safety requirements. The service provided the report for October 2023 which identified areas where the service had not met the trust targets as aligned with national drivers. The report showed that from August 2023 to October 2023 the service had not the met the target rate for midwife to birth ratio and during each month there was an incident where there was not a supernumerary labour ward coordinator.

The service monitored the risk and had highlighted that during August 2023 to October 2023 there was a 7.41 whole time equivalent workforce gap which included staff on maternity leave. Maternity leads had identified actions following the shortfall in staff and a business case had been presented to the board to increase the maternity and medical establishment in response to the increase in acuity.

There were plans to cope with unexpected events. The service had been placed on divert once from October 2022 to October 2023 due to high acuity. The service had a detailed escalation policy and from reviewing the data we could see the service followed policy by pulling staff from PROMPT training and specialist midwives worked clinically to support the service.

There was a serious incident management guidance in place outlining the process of reviewing incidents, including a template for completing the initial 72-hour report. The incident was reviewed in the weekly incident review meeting where the team agreed on the level of harm and actions. The review of incidents was reviewed by a minimum of consultant obstetrician, a member of the senior leadership team and a member of the quality and patient safety team.

Maternity

In the 2023 GMC survey, scores for the trust were significantly higher than the national average for 3 indicators – teamwork, supportive environment, and educational governance. The trust was significantly lower for one indicator relating to 'Local Teaching'. However, medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop.

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. The service used a scorecard to review key performance indicators for internal benchmarking and comparison. They had a live dashboard of performance which was accessible to senior managers.

Staff could find the data they needed to make decisions about women and birthing people's care.

The information systems were integrated and secure. The system was used throughout all trust's departments which ensured access to consistent documentation and contemporaneous care records. Data or notifications were submitted to external organisations and there was evidence provided that the trust reported to the National Maternity database.

The service worked closely alongside the 3-year delivery plan for maternity and neonatal services, working towards national drivers and reporting to Local Maternity and Neonatal Systems (LMNS). The quality governance committee completed the maternity and neonatal safety reports which outlined local and nationally agreed measures to monitor maternity and neonatal safety. Information was reported to the LMNS to identify current or emerging risks.

The service reviewed data to focus on reducing health inequalities using quality improvement methods. The service had recently appointed an inclusion midwife and a performance audit co-ordinator to support the health inequalities agenda to review data and break down statistics by ethnicity.

The information systems were integrated and secure. The service had a digital midwife to support staff accessing electronic information systems. The digital midwife role was to provide digital tools to make processes smooth and safer. For example, the digital midwife had developed a specialist midwife directory online to support ease of communication.

There was also a plan to have an online point of access for booking services and accessing translation services.

Engagement

There were consistently high levels of constructive engagement with staff and people who used services, including all equality groups. They used innovative approaches to gather feedback from people who use services and the public, including people in different equality groups, and there was a demonstrated commitment to acting on feedback. They actively collaborated with partner organisations to help improve services for women and birthing people.

Services were developed with the full participation of those who use them, staff and external partners as equal partners. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care

in maternity services. Service leaders had built meaningful relationships with the MNVP and encouraged them to attend meetings on site. The MNVP were passionate about their role, had regular engagement with leaders to make a difference to services provided to women and birthing partners who accessed the service. The service had worked closely with the MNVP, women and birthing people to develop personalised care and support plans. This was part of the services digital transformation and to develop digital patient records.

The MNVP were well embedded into the service and the trust was open in its engagement with the MNVP and women and birthing people using the service to drive improvement. The MNVP had regular meetings with the trust and easy access to the senior leadership team to escalate any concerns promptly.

Leaders worked with the local Maternity Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Staff spoke positively about the work the MNVP were doing. There was a focus on health inequalities and the MNVP was working with the inclusion midwife to talk to women and birthing people about their birth experiences. The MNVP workforce plan had key action steps, with the focus of listening to women and families.

During the inspection staff had highlighted concerns around the on-call process for midwives. Staff told us not all midwives were confident to work as the midwife on call within the Bath Birthing Centre. Maternity leaders were working with staff on a project around the on-call rota and were engaging with maternity teams. Senior leaders had facilitated several engagement sessions with midwives around the on-call system and continuity models. Leaders told us they recognised the importance of engaging with staff on the long-term vision for on call, to ensure sustainability and staff morale.

Leaders understood the needs of the local population and knew their demographics. The service had recently completed personalised care planning for women. Staff at booking were introducing conversations around ‘what matters to you’ and there was a booklet which was completed from booking to make women and birthing people’s experience more personal.

Staff told us there were regular engagement and listening events provided by maternity leaders. There were regular executive team walk abouts with the chief nurse and chief executive for the trust, as well as monthly board level safety champions walk about and listening events.

From July 2022, the trust provided a weekly dedicated freedom to speak up clinic and staff were encouraged to attend.

The bereavement midwife engaged with national and local bereavement charities to support services for women, birthing people and their families.

The service displayed Ockenden infographic posters in all clinical areas around the unit. The posters were developed by the service for women, birthing people, their families and staff. Posters highlighted a number of actions, including enhanced safety, listening to women and families and informed consent.

Staff had access to stickers which linked policies and ongoing work towards Ockenden standards. A monthly maternity newsletter provided staff with key updates, messages and training. The service also produced ‘The safety catch’ newsletter focusing on a specific incident, actions and learning.

We received 129 responses to our feedback on care posters which were in place during the inspection. Of these responses 81 people gave mixed feedback, 39 gave negative feedback and 9 were positive feedback.

Maternity

Themes from the positive feedback were midwives listened, were kind and caring, however, there was negative feedback around a lack of communication, poor staffing within postnatal care and delays in inductions of labour.

The maternity matrons ran a quarterly forum with the maternity and neonatal voice partnership, birth doula's, antenatal teachers, hypnobirthing teachers and yoga teachers to provide communication within the wider birthing community. The forum enabled the service to work collaboratively, with a shared vision of personalised care and support for women and birthing people.

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. Safe innovation was celebrated. There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology.

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. Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Quality improvement (QI) was routinely discussed at quality improvement meetings and governance meetings. There was a quarterly Maternity and Neonatal Quality Improvement Meeting with the purpose to review an action tracker for all quality improvement review findings and to discuss updates.

The service had a QI tracker which included an overview of Maternity and Neonatal quality improvement projects. There was also a QI team's channel within the Maternity & Neonatal Quality Improvement channel for shared access to documents and the QI tracker. Examples of projects on the QI tracker were, improving the relaxation room in Bath birthing centre, improving multidisciplinary working relationships and the implementation of a standardised risk assessment tool for maternity triage.

Audit findings from quality improvement were continuously assessed and if required adapted to improve services. For example, within each audit the team reviewed the strengths and weaknesses within the audit. This was to identify recommendations or changes required.

The service monitored equality, diversity and inclusivity. Updates were provided to staff to increase staff awareness, improve quality data in relation to health inequalities and to reduce the differences in access to services between women in white and black ethnic groups. The service had an equality and diversity book club and there was a roll out of anti-racism training with the aim to have had all staff completed by March 2024.

We saw improvement huddles quality and performance boards in all clinical areas. The boards were in place to improve communication between teams and teams to be involved in improvement projects and patient safety priorities.

Maternity

To support maternity staff to develop initiatives, ideas and projects awarded the service had created a 'Maternity Development Panel'. The purpose was to support staff to develop their own projects and ideas and there was funding to support staff to complete.

The retention and education team worked with the Senior Leadership Team to implement various changes, which had a positive effect on staff retention and compassionate leadership in the workplace. The retention midwife implemented a 3-year recruitment and retention strategy and had identified key factors to contribute to staff retention. The service was asked to share their work nationally via forums. For example, the service had published an NHS England good practice paper and to present at South West midwifery forums.

The Milk Project was piloted by maternity and neonatal services within the Local Maternity and Neonatal systems (LMNS). The aim of the pilot was to reduce health inequalities. Pregnant women and birthing people within specific local areas were offered additional support around infant feeding in pregnancy to learn more to when their baby is born to reach their feeding goals.

The RUH had received UNICEF Baby Friendly level 3 accreditation in both Maternity and Neonatal services in October 2023 and the team were working on obtaining gold standard, to help the sustainability in the team.

A maternity and neonatal communication plan had been developed by the team to improve engagement with staff. The plan aimed to provide 8 steps to better engagement. This included talking, welcoming and supporting staff, hosting maternal and neonatal forums, walk and talk sessions, opportunities for feedback, shared learning, time to meet senior leaders and regular staffing updates.

The Royal United Hospital (RUH) obstetrics and gynaecology training team were nationally recognised and were winners of the Royal College of Obstetricians and Gynaecologists, National Obstetric Training Programme award in 2023.

The service was the first in the country to offer a multidisciplinary approach to have maternity and medical students training together.

Outstanding practice

We found the following areas of outstanding practice:

- A maternity and neonatal communication plan had been developed by the team to improve engagement with staff. The plan aimed to provide 8 steps to better engagement. This included talking, welcoming and supporting staff, hosting maternal and neonatal forums, walk and talk sessions, opportunities for feedback, shared learning, time to meet senior leaders and regular staffing updates.
- To support maternity staff to develop initiatives, ideas and projects awarded the service had created a 'Maternity Development Panel'. The purpose was to support staff to develop their own projects and ideas and there was funding to support staff to complete.
- The service ran a forum with doulas, antenatal workers, hypnobirthing teachers and other professionals working with women and birthing people in the community to open channels of communication and to work collaboratively on providing personalised care and support.

Maternity

Areas for improvement

Action the trust SHOULD take to improve:

- The service should ensure the compliance for emergency training and adult basic life support training meet the trust target for compliance.
- The service should make sure all women and birthing people are asked the relevant safeguarding questions at each contact.
- All staff should be compliant with infection control compliance and hand hygiene.
- All staff should complete the daily checking of emergency equipment.

Our inspection team

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