South Warwickshire University NHS Foundation Trust

Warwick Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Warwick Hospital

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Warwick Hospital.

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

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

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

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

Warwick Hospital is rated Good and South Warwickshire University NHS Trust is rated Outstanding .

How we carried out the inspection

During our inspection of maternity services at Warwick Hospital we spoke with 30 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the antenatal clinic, maternity triage, labour ward, birth centre, day assessment and postnatal ward We reviewed the environment, maternity policies while on site as well as reviewing 10 maternity records. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We did not receive any feedback from the poster campaign. However, the trust shared with us some feedback they had received from their internal surveys completed recently. These reflected a kind and caring workforce who supported people during their stay in the maternity unit.

The trust provided maternity services at hospital and local community services and approximately 3,000 babies were born in the trust during 2022.

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

Maternity

Good

Our rating of this service stayed the same good. The rating for safe improved to good. and well led improved to outstanding.

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people from all cultures and communities to ensure an open approach with individualised plans to manage the service.

However

- There were at times delays for medical staff to complete required training to meet the trusts targets, and to provide assurance staff were always trained in the required areas.

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff were up to date with mandatory training.

Nursing and midwifery staff received and kept up to date with their mandatory training. The Trust training target ranges between 85% - 95% depending on the training.

We saw the training compliance was monitored, nursing and midwifery staff compliance did not fall below 85% and in the majority of cases exceeded 90%. These were monitored and additional training or support was offered to improve the levels of compliance to the trust 95% target.

The service supported staff to develop their skills and knowledge through additional training. These included, breech births, new-born life support and acupuncture and hypnotherapy to name a few. Covering areas to support safety and high-risk births in addition to training to support alternative therapies.

However, medical staff had not met the trusts targets. For example,65% for infection, prevention, and control and an average 80% in all other areas. This meant this training did not meet the trusts targets. After our inspection, the service provided further data to support an increase in the training to 85% and how they planned to meet the trust targets in the future.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. The service provided training and competency-based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Nursing and midwifery staff compliance was 97% with bank midwives at 94%

Doctors and registrars had also received training in CTG, we reviewed training figures which showed some figures were as low as 77% and 88%, however we saw further training which had been completed showed 100% compliance. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

The Practice Development Midwife monitored mandatory training and alerted staff when they needed to update their training. A range of measures had been introduced to support staff with their training and learning needs. For example, up skilling staff with 'itchy feet' conversations. This has enabled staff to progress training needs into new roles or to expand their skills in their current roles to support retention.

Staff completed regular skills and drills training. Records showed the variety of situation skills completed. For example, a pool evacuation exercise was completed on the birthing unit. The scenario depicted a woman with a low blood sugar, and they required evacuation from the pool. The staff identified it was in relation to low blood sugar however the exercise identified the unit did not have a glucometer. This has since been purchased. This shows the skills and drills exercises provide staff with direct learning and an opportunity to identify any equipment requirements or additional areas of training.

Midwifery staff had also completed training in advanced life support and neonatal advanced life support training. Nursing and midwifery staff compliance was between 91% and 94%. This meant that staff had training to provide lifesaving treatment to women and babies in their care.

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, however, not all staff had completed it.

Staff received training specific for their role on how to recognise and report abuse. We looked at the contents of the safeguarding training that staff completed; it covered expected modules for safeguarding level 3 training in line with national intercollegiate guidelines.

The trust target for safeguarding training was 85%. Nursing and midwifery staff compliance with training targets was 90% This met the trust target. Support staff/unregistered nursing staff were also required to complete training and were compliant with the trusts target.

Training records showed that staff had completed both Level 3 safeguarding adults and level 3 safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

However, we found medical staff overall compliance with safeguarding training targets was 47%. This meant the medical staff did not meet the trust target and the trust could not be assured of medical staff having the required knowledge to prevent people from the risk of harm. After the inspection, the service provided further data which showed that in May 88.23% had been achieved by the medical staff. Meeting the trusts target.

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.

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. This was a mandatory field in the electronic records system. Where safeguarding concerns were identified, women and birthing people had birth plans in place, staff were supported with input from the safeguarding team.

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.

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 should a baby be abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. The service audited cleaning checks every week. We looked at audits for the last 3 months and found the compliance was 98%.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had effective processes in place to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit and the audit for hand hygiene. We saw were areas required improvement these were identified to the ward manager to make the improvements. Hand hygiene at the most recent audit reflected 100%.

Staff cleaned equipment after contact with women and birthing people. We saw cleaning stickers applied after items had been cleaned and areas maintained a high level of cleaning standards.

Environment and equipment

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

Maternity

The design of the environment followed national guidance. Safety around the security of the wards was considered, the maternity unit was fully secure with a monitored entry and exit system. The wards had CCTV to enable a visual and verbal discussion before access was agreed. We saw birthing partners were provided with a coloured band so they could be identified for access. Baby tagging was being trialled to consider the effectiveness of the system. We reviewed skills and drills completed around possible baby abduction, this reflected staff had the required training to respond to protect the babies and other families.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily. Other trolleys containing required equipment for routine care were also checked daily and recorded.

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. Manual handling both theory and practical were completed. These supported the needs to transfer a woman if needed or to evacuate from the birthing pool. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

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

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

The service had developed the environment to meet the needs of women and birthing people. For example, they had developed an area to introduce a triage system to enable early signs of concerns to be addressed or to provide assurances to women and birthing people. The labour ward birthing room had been redesigned to accommodate a birthing pool and modern furniture. This meant women of high risk could still receive a birthing experience. The theatres were also due to be refurbished to accommodate the increased numbers of caesarean sections.

Assessing and responding to risk

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

During this inspection we reviewed the service's maternity quality dashboard. The dashboard reported on clinical outcomes such as PPH (postpartum haemorrhage). We saw these figures had increased against the national average. The service had developed an action plan to address this increase. This included raising awareness with additional training and increased monitoring. This showed the service used the data to measure against national reporting and to take action when areas of concern were noted. The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

The dashboard provided data on babies born before their due date. This was used to monitor information about the birthing journey and if all the required recording and measures had been taken to consider an early delivery.

Maternity

The service recorded postnatal readmissions within 14 days. We saw when women were readmitted, they were seen by a doctor, and provision made for their baby to be with them.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in detecting women and birthing people who may be seriously ill. The MEOWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and to ensure prompt management of any women whose condition was deteriorating.

The service recognised a concern in relation to the completion of MEOWS raised by midwives and conducted an audit in January 2023. The results showed a lower level of compliance with MEOWS guidelines. The service took action to re-write the MEOWs guideline to ensure suitable escalation and a focus on training for staff. Further monitoring and audits would be used to review the levels of compliance. This shows the service was reactive to concerns and ongoing action was developed when required to make improvements.

A system was in place to support women and birthing people with their birthing journey, which was triaged based on the levels of concern. Staff completed risk assessments for women and birthing people on arrival at the hospital, using a recognised tool, and reviewed this regularly, including after any incident. The triage system used was based on, The Birmingham Symptom-specific Obstetric Triage System (BSOTS). This system provides a standardised assessment of women on presentation, followed by clear guidance developed to help midwives and clinicians determine the clinical urgency in which women need to be seen.

This system had only been in place for 2 months and was not completely embedded in relation to the recording of times when women were seen by the midwife and the doctor. An audit process was in place to review this area and to develop the service.

After our inspection we were provided with data which reflected the maternity triage waiting times and times to be seen by a doctor. We saw the overall waiting times were within the agreed timeframes. Feedback from women and birthing people using triage had been obtained and reflected a positive experience, with their risk or concern being addressed swiftly and in a kind and caring manner.

The service provided a telephone contact service supported by a midwife. They were able to provide advice and direct the person to attend the triage unit to address the concern. Any women or birthing person who did not attend following advice to do so, was followed up. This ensured any potential risk for the women, birthing person, or baby was mitigated.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used to monitor fetal heart rate and uterine contractions. Best practice had a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG audits which showed 100% compliance. On site we observed how staff recorded the fresh eyes on the electronic system and on the wipe board as a visual reminder for the next planned time check.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and we found with the exception of 1 case all the required checks had been completed. The service was moving to an electronic version of the WHO checklist to ensure the correct sign off with a more formalised audit trail.

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. The service had just engaged two perinatal midwives to support the needs of women and birthing people who may experience difficulties with their mental health either during or after birth. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

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

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. We saw a print off was produced for the team handover which provided details of the care received to date and any required actions. For example, blood tests or new-born and infant physical examination (NIPE) assessment for the baby.

Staff completed new-born risk assessments when babies were born using recognised tools and reviewed this regularly. The NIPE screens babies for specific conditions, ideally within 72 hours of birth. The service audited completion of NIPE examinations and we saw these were completed within the agreed timeframe.

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

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

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

Midwifery Staffing

The service had no issues with recruitment and retention and sickness of staff. Staffing levels matched the planned numbers ensuring the safety of women and birthing people and babies to reduce any risks. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers accurately calculated and reviewed the number and banding of midwives, maternity support workers, nurses needed for each shift in accordance with national guidance. The service was awaiting a birthrate plus review for their staffing and acuity. However, the service had undertaken their own assessment of staffing and acuity.

The trusts acuity assessment identified areas of risk and additional staffing were required to maintain safety and to provide women and birthing people with the required level of support. For example, an additional midwife at night on Swan ward. Further recruitment was completed to support the introduction of the triage assessment and additional staff for the theatres. This meant the service had been proactive in considering staffing needs to ensure safety and quality of care was considered across the service.

Maternity

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. We saw how the red flags were recorded and reviewed to consider themes or areas where staffing had dropped below the required level. These themes included when senior staff were not supernumerary, during March this reported 13 occasions. Other metrics included a delay in induction of labour and staffing falling below the minimum levels. All these areas were investigated to consider measures to reduce these events reoccurring.

There was a supernumerary shift co-ordinator on duty who had oversight of the staffing, acuity, and capacity across the maternity service. The ward manager was able to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

The number of midwives and healthcare assistants matched the planned numbers. We reviewed the planned versus actual staffing in the department for the last 4 months. We saw the actual staffing overall met the needs for planned staffing. This meant the staffing was in line with the planned numbers and women were treated and cared for in line with the expected standards of care.

We looked at the staffing report over the last 4 month, sent to the trust's board. These reports reflected staffing recruitment, absence, and requests for additional staffing.

Staffing was considered by the board and recent business cases to increase areas of staffing had been approved. For example, a team of staff to support the theatres.

The service had low vacancy and limited turnover rates. We saw the service used bank midwives and nurses and redeployment to support any staffing needs to meet safety levels. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff were given opportunities for development as part of their annual appraisal. This was done through training, attending conferences, support, and supervision. We saw several staff had achieved internal career development or promotion.

The service has a practice development midwife and a practice development neonatal nurse. They were responsible for reviewing the training schedules, ensuring the required levels of attendance and competence. We saw incidents and events were used within the training to provide practical learning opportunities.

A training needs analysis was completed to ensure it met the Core Competency Framework Plan. We saw how the training programme was divided into areas which covered the core required learning, PROMPT, E-learning, or some specialist training e.g.: diabetes or suturing.

There were 24 specialist midwives in place to support women in different areas including Perinatal Mental Health Midwife Lead, diabetic and retention midwives. We discussed the service with several of the specialist midwives to understand their roles and how they support the different needs of women and birthing people.

Medical staffing

The service had 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.

Maternity

The service managed their medical staff to ensure there was enough to keep women and birthing people and babies safe. The service had 6 senior house officers with 2 vacancies. 9 registrars and consultants with 1 vacancy for each role. Whilst recruitment was ongoing locum staff supported these areas.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

The service had a good skill mix and availability of medical staff on each shift which was reviewed regularly. The service always had a consultant on call during evenings and weekends, who attended two daily walks around as per the national recommendations. Within the antenatal section junior doctors had identified that there was often a back log of women waiting to be seen at the end of the day. The junior doctors reconfigured their shifts to provide a twilight shift to support this area and reduce the waiting times.

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

Records

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

Women and birthing people's notes were comprehensive and held on an electronic system with the exception of medicine records which continued to be paper based. We saw all records were accessible to all required staff. Records were stored securely. Staff locked computers when not in use and any medicine paper records in locked cabinets. The service audited records every month. We looked at record audits for the last 6 months and found overall the required fields had been completed. During our inspection we reviewed 10 electronic records and found the information to be completed in accordance with the trusts policy on record keeping, with all required fields completed.

When women and birthing people transferred to a new team, staff used a nationally recognised handover tool known as SBAR. This approach consisted of standardised prompt questions in 4 sections. This ensured staff shared concise and focused information. It allowed staff to communicate effectively, reduced the need for repetition and errors. We saw within the handover there was a focus on SBAR communication to improve the handover approach.

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. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. During our inspection we reviewed 10 medicine charts and found these had been completed correctly in line with the trust policy.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed.

The service had systems in place to check staff competency in relation to medicines administration in line with trust policy and national guidelines. We saw medicines management competency figures were monitored and these exceeded 85% and staff had been signed off as competent.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily in line with trust policy. Staff monitored and recorded fridge temperatures and completed daily records on site. Any variation in temperature which could impact the integrity of the items stored inside was reported and actions taken to address the situation to maintain safety.

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.

The service managed incidents well, staff could describe what incidents were reportable and how to use the electronic reporting system.

The service currently had no 'never' events. Managers shared learning with staff about never events that happened elsewhere within the trust or previously when they had occurred. The service had a 'learning from incidents' midwife who was responsible for sharing learning with staff.

Managers investigated incidents thoroughly. They involved women, birthing people, and their families in their investigations. Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Incidents were investigated and responded to in a timely way; there were 5 incidents open over 60 days. However, of these, 1 had been authorised to close at the board, 3 others were Perinatal Mortality Review Tool (PMRT) cases awaiting post-mortem for full sign off. In all the investigations, managers shared duty of candour and draft reports with the families for comment.

In the last 6 months 1 incident had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation. The service reviewed all neonatal deaths by a multidisciplinary group who used the PMRT. We reviewed the perinatal mortality tool, and we saw they had been completed appropriately.

The service was 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 received feedback from investigation of incidents, both internal and external to the service. For example, we saw Staff discussed incidents at the Clinical incident learning forum, and these were shared through electronic systems and a closed social media platform via Friday Feedback Newsletter for staff who could not attend in person Friday Feedback. Other incidents were used on the training programme to reflect on learning and improvements to the care of women and birthing people.

Maternity

Managers debriefed and supported staff after any serious incident. We saw a 72-hour review was completed and staff were supported by the Professional Midwifery Advocate (PMA). The service had recently added a box to their datix recording records to identify if PMA support was required. This meant there was a clearer line of support and better understanding for senior managers on when staff required support.

Is the service well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

Leadership

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. We saw leaders had the skills and abilities to run the service, understanding and managing the priorities and issues the service faced. Leaders were visible and approachable in the service for women and birthing people and staff. Strategies were in place to develop the desired culture and to support staff with skills and opportunities for more senior roles.

There was a clearly defined management and leadership structure in place, which showed compassion, inclusive and effective leadership at all levels. The service was led by an operations officer, with a director of midwifery and neonatal services across South Warwickshire NHS Foundation Trust and another local NHS Trust. The triumvirate was made up of an Associate Director of Operations Family Health, an Associate Director of Midwifery (DoM), and Associate Chief Medical Officer for Family Health.

There was clear oversight of the service with appropriate lines of reporting to various meetings, to ensure a clear line of communication between the ward and the board and any agreed actions or developments.

Senior leaders and safety champions were visible and demonstrated levels of experience needed to deliver excellent and sustainable care.

Executive leaders and board members had fully embedded system of leadership to ensure succession planning and developments within maternity around staffing and the development of the environment. For example, the refurbishment of the labour ward rooms to make them more inviting and less clinical for women and birthing people who were of higher risk. This meant high risk women and birthing people could have a similar experience to that received in the birthing centre.

Leaders had the skills and abilities to run the service, and a deep understanding of issues, challenges, and priorities. They understood and managed the priorities and issues the service faced. For example, staffing numbers, staff development and the environment. Plans for future developments were shared with staff, to reflect their clear understanding of the challenges to quality and sustainability within the service.

Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. They saw the executive team regularly and spoke of how accessible and encouraging they were.

Maternity

The leadership team were focused on the retention of existing and new staff and ensuring it was representative of the required diversity of the workforce. The retention midwives had a range of opportunities for staff to either develop their skills or to work alongside others to consider future opportunities. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. This provided a sustainable career pathway and framework that supported talent mapping and succession planning.

The service was supported by maternity safety champions and non-executive directors. The safety champions completed a walk around on a monthly basis. Actions from these were shared with senior leaders and staff, for example the introduction of a refreshment trolley on swan ward and other changes to the environment to support choice, flow, and safety.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust had an overarching strategy and plans were fully aligned which demonstrated commitment to system-wide collaboration and leadership. There was a clear set of objectives and the maternity directorate had developed their own set of objectives, under these themes.

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

The maternity service for 2023-2024, entitled 'Delivering our big moves.' had a detailed plan which set out how the objectives will be delivered, the actions required and the responsible staff members or leaders. In addition to the main objectives there was also quality objectives which focused on patient's experience, safety, and outcomes.

Leaders had considered the results of an assurance visit in April 2022 undertaken by NHS England team which detailed a series of actions to bring the maternity unit up to the required standards. There was a systematic and integrated approach, with twice monthly meetings with the MDT worked through the action plan and significant progress was being made. We saw example of actions, the audit pathway, 15 steps exercise with the Maternity voices Partnership and improvements to the bereavement service had been completed and improvements made. Any remaining actions concerning patient safety were followed up through other work streams such as saving babies lives, digital and transformation.

Culture

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.

The leaders within the service had a shared purpose and strived to deliver and motivate staff to succeed. The culture within maternity services supported staff to develop and fostered a culture of learning and improvement. Leaders led by

example and acknowledged that their behaviour(s) percolated through the service. There were high levels of satisfaction across all staff, they told us they were proud to work for the trust and felt valued and respected by management, they were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

All areas of the maternity unit and The Blue Bell birth Centre were women and birthing people focused, ensuring individuals needs and voices were heard in all aspects of their birthing journey.

There was a strong team-working and support across all functions with a common focus on improving the quality and sustainability of care and people's experiences. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people.

Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Leaders understood how health inequalities affected treatment and outcomes for 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.

The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. The service had an equality, diversity and inclusion policy and process. Staff told us they worked in a fair and inclusive environment. For example, support was provided to enable staff time for prayers or support during religious periods and celebrations. We saw the senior leaders were working to establish support systems for staff from other cultures.

Addressing equality and inclusion and health inequalities had become regular agenda items at meetings between maternity services and their maternity voices partnership. The maternity voices partnership (MVP) had developed links with different venues to engage with women and birthing people who could be harder to reach.

We saw groups being developed in places of worship and community centres, to support Hindu, Muslim, and Polish groups. The MVP were also talking to the local authority about Ukrainian refugees to support those women and birthing people.

There was a connection with Warwickshire pride, parents' group who met weekly and the MVP were supporting a summer event. Access had been established to provide interpreters and signers to consistent hearing-impaired women and birthing people to support continuity of care.

A community directory has been developed to provide information of where parents could go for support. Posters have been displayed to promote the service and shared in a variety of locations including specialist hair salons such as for women of Afro-Caribbean background[WJ1] .

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. We saw when incidents were reviewed, any aspect of a cultural inequality having occurred was investigated and addressed with staff. For example, one incident reflected a lack of communication, this was discussed with staff and a reminder about the use of interpreting services.

Maternity

Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service received 4 complaints in the 3 months before the inspection. We reviewed all complaints and found all aspects of the complaints had been investigated. Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. For example, we saw following one complaint the scanning and appointment process had been improved. Parents were responded to with formal letters referencing duty of candour, the investigation and any learning or direct actions taken.

After our inspection, a complaint was received with regard to communication to partners on the swan ward. The trust used these concerns to review an information booklet for partners and with support from the complainant to ensure the information was easy to understand. This showed the trust was proactive in dealing with complaints and driving improvements.

We saw when complaints met national guidance investigations, for example Perinatal Mortality Review Tool (PMRT), the process was explained to parents with the required timeframes. Parents were then supported through the PMRT process.

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

The maternity and neonatal safety champions met monthly. We looked at meeting minutes for the last 6 months and reviewed the actions taken to address different aspects of the service. For example, reviews of actions on the Ockenden (2020 and 2022) reports, the desk space capacity, safety issues and any other aspects which could impact safety.

Each month the Maternity and Neonatal Safety Champions complete a Walk Round to chat to staff about some of their concerns and review the environment. Any actions were shared with senior staff and on the Friday Feedback meetings.

Oversight of safety in maternity services was reported to the board quarterly. We reviewed the last 2 reports and found all aspects of maternity were reviewed. For example, any national reporting tools in use and the progress to date, staffing, environmental restrains or any other aspects which required sign off or a response from the board.

The service shared with the board the Local Maternity and Neonatal Systems (LMNS) developments. These included ‘A Strategy for Digital Transformation in Maternity'. This is part of the NHS Long Term plan which recommends, "by 2023/ 2024, all women will be able to access their maternity notes and information through their smart phones or other devices." We saw plans were being developed to enable this to be available.

The LMNS had also developed an Equity and Equality plan. This set out the key actions that the LMNS should take forward collaboratively over the next three years. The plan supports interventions to reduce health inequalities, a communication plan was being developed and consideration on what resources will be required to drive the agenda forward.

Governance

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

Maternity

The service had a strong governance structure which worked proactively to support 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 meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues.

There were opportunities for managers to meet with the senior management team on a regular weekly and monthly basis, and key areas including performance, staffing and incidents were discussed in these meetings.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board, and from the board back to the ward.

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. Clinical governance meetings were held monthly. We looked at meeting minutes for the last 3 months which provided details of the meetings, national reporting requirements and reviews of any risks in relation to staffing and incidents.

Senior leaders managed workforce plans well. The service was awaiting a Birthrate plus assessment to consider staffing levels within the unit. However, the service completed an internal workforce review in January 2022, to support staffing increases to ensure the safety of the units.

Business cases were presented to the board to consider additional staffing to develop the service. For example, staff to support the introduction of the triage unit. The business case reflected the benefits not only to the women and birthing people, but also the improvements to the labour ward and staffing being dedicated and focused to establish roles. Prior to this staffing increase staff were moved from providing one to one care or staff working as supernumerary were required to provide hands on support. This meant an improvement to the triage process and care on the labour ward.

We saw other workforce plans were developed in other areas of maternity, for example post-natal ward recruited an additional midwife at night and staff support in theatres was increased. Both business cases used data in relation to the number of births, staffing and the potential impact of safety to gain board approval for the recruitment.

Senior leaders in maternity services met weekly. We looked at the agenda from these meetings which included general check-in, maternity update, risk issues, medic and maternity rota, paediatric update/risk issues. Actions from these meetings fed into other meetings, including governance and safety meetings.

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, through Friday Feedback.

There was an effective policy in place to manage the department when it was in escalation. We looked at the policy and saw there were clear actions in place to mitigate risks and manage levels of staffing to meet the needs of women and birthing people. For example, we saw a clear use of staff in The Bluebell Birth Centre supporting community midwives to support and facilitate home births. We also saw how systems were in place to escalate staffing concerns across the maternity units to reduce any day-to-day risk.

Maternity

Governance boards were clearly visible in every clinical area. These detailed, risks, safety issues, any new guidance, training, incidents, lessons learnt and celebrating success. These were reviewed and updated. During staff handover a safety briefing was reviewed, and a printed copy made available for staff to reference. At the end of each shift the print off was disposed of securely to maintain women's confidential details.

The service had a systematic approach to working with other trusts and organisations to improve care outcomes. A daily midday webinar meeting with two other local NHS trusts, was held to review the maternity and neonatal status. The calls provided an opportunity to facilitate any available support. For example, transferring some women or birthing people to another hospital who were able to facilitate their needs and reduce pressure on the other trust.

Leaders monitored policy review dates on a tracker and reviewed policies every 5 years to make sure they were up to date. The policies we reviewed were all in date and included any new guidelines or standards.

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.

The service used relevant national clinical audits to demonstrated commitment to best practice performance and risk management systems and processes. 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.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed.

The service managed and monitored any closures, for example, The Blue Bell birth centre which is a midwife led unit, over the last 3 months had been closed 6 times in January and February and 9 times in March. Each closure was for hours not full days and on each occasion alterative arrangements had been made for women and birthing people.

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. These were shared weekly at the Friday Feedback sessions and on the notice boards within each maternity section.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had an incident investigation procedure which showed the flow of action from receipt of the incident, which detailed the action against the severity of incidents. It detailed the criteria for the national reporting framework and following a 72-hour review identifying any immediate actions ahead of it being reviewed at the weekly incident meeting. We reviewed the policy and saw the procedure had been followed.

The service reviewed incidents that have been reported in the previous seven days to identify any action required at trust level, completion of a serious incident if it met the criteria, or external reporting. Each incident was reviewed by a multidisciplinary team and any required actions taken forward.

There was an effective system in place to review and monitor actions from HSIB (Healthcare Safety Investigation Branch). The service had no ongoing HSIB cases from the last the last 6 months.

Serious incidents review meetings were held, and we looked at minutes for the last 3 months. We found a detailed investigation had been completed and any learning reflected in training, feedback session or skills and drills.

The service worked with MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) to ensure they reported any maternal deaths. We saw the service reviewed all the information and this was shared with the board, seniors, and staff to reflect on learning. There were clear reporting and timeframes, which had been improved over the last 12 months and clearer written information and communication with families.

The service had a risk register in place. We reviewed the risk register and saw the service had recorded any incidents rated as high or extreme risks. Against these was the mitigation actions and actions to address the risk. For example, nitrous oxide levels in Delivery Rooms on labour Ward and The Bluebell Birth Centre. We saw control measures were in place and ongoing action to purchase wearable meters to test environmental conditions. The register stated clear ownership of the risk, timescales for review or completion.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. A total of five out of the 10 safety standards had been completed. An Action Plan and a bid for funding had been put forward to help increase support for the Clinical Negligence Scheme for Trusts (CNST) requirements. The service maintained an ongoing action plan which was monitored along with being reviewed as a risk whilst it had not met all 10 standards.

The service complied with the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care. For example, smoking in pregnancy, the rates of CO at booking and at 36/40 remains compliant and continue to be monitored. In relation to fetal growth, it was noted the service are introducing uterine artery dopplers for high-risk pregnancies and will monitor its usage, A uterine artery doppler checks the blood flow of the uterine arteries, this can inform details about the baby's growth potential and the risk of pre-eclampsia. We saw all areas had auditing measures in place and ongoing next steps.

We reviewed the trust's compliance with the perinatal clinical quality surveillance model. The tool was used to strengthen trust-level oversight for quality and taking proportionate action and triggering escalation. We found a consistent approach to reporting and addressing any areas of concern.

A local business continuity plan was in place to cope with unexpected events.

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 maternity service demonstrated commitment at all levels to sharing data and information proactively to drive to support internal decision making as well as system-wide working and improvement. We saw performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers, enabling internal benchmarking and comparison. Data was shared with the staff to reflect any improvements in the data or areas where further improvements maybe required.

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

The service used an electronic recording system which was password protected for each staff member, this ensured they were secure**.**

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

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. Maternity voices partnership engagement meetings were scheduled monthly and covered feedback, ongoing projects, or developments within maternity, along with new initiatives and community work.

We reviewed the minutes of the most recent meeting. We saw a range of topics were discussed. There was a positive relationship between the service and MVP. Links with the safety champion had been enhanced by the MVP joining the monthly walk around. There was shared working around developing videos and using social media to engage with people whose first language was not English or who may struggle with written information even if provided in their own language. Younger parents also benefitted from videos and social media platforms for information.

The service used innovative approaches to gather feedback from people who use services and the public. We saw the MVP linked up with local and national campaigns for example, ‘Dads matter’ and ‘Love Your Bump’ campaign.

The Dads 'matter app is currently only licensed within the Birmingham area. It has been promoted on the MVP Facebook page. Every quarter, feedback is provided on the top three subject’s dads were accessing. This was used by the trust and the MVP to consider how these can be linked up in providing information or action.

The services ensured full participation of those who use the services, staff, and external partners as equal partners, when developing the strategy. We saw that a partnership approach had been used to revise the strategy, website, and changes to the maternity unit.

The MVP were recruiting Community Champions and developing their relationship with Trust. We saw midwifery staff had taken part in the interviews. Those champions which had been recruited attended the latest meeting and shared their knowledge and ongoing champion role.

Maternity

The MVP had completed 15 steps review in June 2022. This quality tool reviews the service from the perspective of people who use maternity services. Any elements raised from the 15 steps were reviewed and actions developed. One issue noted was the number of posters on Swan ward, which could be overwhelming. Follow the review these have now been scaled down and moved to a more accessible location. Further consideration was being made to develop a laminated book for the information to ensure no leaflet was omitted.

Learning, continuous improvement and innovation

Improvement was seen as the way to continually learn and improve services to deal with performance for the organisation. All staff were committed to a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a clear, systematic, and proactive approach to seeking out and continually learning and improving services. The service was committed to improving services by learning when things went well or not so well and promoted changes through training and innovation.

The service produced and circulated newsletters called 'Friday Feedback' to staff weekly. We looked at 3 of the most recent newsletters and saw these provided a combination of information, appreciation, and thanks, as well as opportunities for support or wellbeing. For example, wellbeing walks, had been developed and enabled staff to take time for themselves or receive some support in a different environment. Staff we spoke with told us the feedback information forum was an opportunity to receive information about any ongoing incidents or issues, as well as the good stuff. We saw staff were engaged in conversation about their ideas and innovations.

Quality improvement was routinely discussed at the quality improvement meetings. We saw a range of subjects had been discussed with speakers to support these areas.

The service had obtained some national achievements. The BFI level 3 award, this reflects a service where parents have been supported to have a close and loving relationships with their baby, and that babies were enabled to breastfeed/ receive breastmilk when possible. Also, the service obtained the BLISS Baby Charter Gold Award, for units following an assessment, under the Bliss Baby Charter principles.

The service shared work which was local and national to support systems and had introduced, 'The real birth digital programme' for women and birthing people. This provided a more in-depth understanding of the birthing journey, with a course of 6 hours over different modules. The programme is available in a range of languages which could be selected by the participant. Data from the usage of the programme was shared with the midwives. It is still early in its introduction, however within week 1, 63 people had accessed the programme and week 2, 104. The data provided ethnic breakdown and ages so the service could use this detail to provide any further focused work in this area.

There was an embedded system to consider and develop improvement, which reflects national measures and good practice. Over the last 12 months, the bereavement pathway was being enhanced to a 7 day service. In the interim several bereavement champions working clinically were available should there be a death at a weekend. This would then be picked up by the bereavement midwives as soon as possible after the weekend.

New links had been made with a variety of religious organisations to support loss. For example, the recording of a blessing by the Hindu priest to support family with their loss. The service had received charity support to enable cold cots, transportation boxes and a pram to be provided to give families every opportunity to have time with their baby.

Links had also been made with a funeral director to arrange professional funerals. There were memory making opportunities and access to counsellors. Ongoing links with charities provided ongoing support.

There was a Rainbow Garden with a jasper tree, which provided the opportunity for families to add a memory leaf to the tree and spend time in the garden which was secluded and peaceful.

The bereavement service supports baby loss from 20 weeks gestation, under 20 weeks was supported in gynaecology where they had their own bereavement team. However, the teams work together. For example, to provide a palliative birth plan. A rainbow clinic had been set up with the support of an obstetric consultant, providing families with the support in future pregnancies.

The bereavement lead had introduced coffee mornings, to share with staff completion of paperwork or to give support following any baby loss delivery. Midwife champions ensured skills and knowledge were shared across the service when required.

A diabetes service to women and birthing people provided a consistant approach to support for pre-existing diabetes and gestational diabetes. The service introduced the GDM health app, which enabled blood readings to be shared so the maternity diabetes team could respond swiftly to any changes in blood sugar levels. The introduction of the app had reduced the number of outpatient appointments as the readings could be reviewed and actioned.

Prior to women and birthing people attending their clinic appointment, the team held an MDT meeting, to discuss the best plan for each person. This meant a plan could be shared and actioned swiftly following the appointment. Two insulin review clinics were being set up to provide support and contact for this group of women and birthing people.

The service recognised the increased need in this area with 80-90 referrals a month. The issue was placed on the risk register and a business case developed to grow the team. Now there is a linked consultant, dietician, two band 6 midwives and the band 7 midwife lead. The service is available Monday to Friday with an on-call service.

Outstanding practice

We found the following outstanding practice:

- The bereavement pathway was being enhanced to a 7-day service. Providing a more transparent approach with parents after baby loss. Increased links with a range of cultural groups to ensure that the required religious blessings and cultures were reflected. Development of a rainbow clinic and integral support of a consultant for future pregnancies. Increased staff training and awareness in bereavement to ensure support was available from all staff.
- Improvement opportunities were seen as the way to deal with performance to promote areas and to increase learning. The service provided a diabetes service to women and birthing people with pre-existing diabetes and gestational diabetes. The introduction of an APP to support monitoring and reflective action, increased staffing to reflect the number of referrals and additional clinics to provide clear pathways about the service and support available.
- The governance processes and procedures were well established and proactive in promoting and developing the safety of the service.
- The maternity service demonstrated commitment at all levels to sharing data and using information proactively to drive internal decision making as well as system-wide working and improvement.

Maternity

- The maternity service supported and engaged with women and birthing people with high-risk care needs including from ethnic minority backgrounds, to ensure a safe birthing journey.

Areas for improvement

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

Action the trust SHOULD take to improve:

The trust must ensure that all mandatory training for medical staff can be completed without delays to meets the trust targets, in particular infection prevention and control and safeguarding training.

Our inspection team

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