Wirral University Teaching Hospital NHS Foundation Trust

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Inspection report

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Ratings

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

Our findings

Overall summary of services at Wirral University Teaching Hospital NHS Foundation Trust

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 Wirral University Teaching Hospital NHS Foundation Trust, also known as Seacombe Birth Centre.

We inspected the maternity service at Wirral University Teaching Hospital NHS Foundation Trust, also known as Seacombe Birth Centre, 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.

The inspection was carried out using a pre-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visit, we conducted interviews with senior leaders, specialist staff and stakeholders. We held focus groups for staff of all grades and roles and reviewed feedback from women and families about the trust. 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 analysed the results to identify themes and trends.

Wirral University Teaching Hospital NHS Foundation Trust, also known as Seacombe Birth Centre is 1 of 2 sites for maternity services for the trust. It is a stand-alone midwifery led unit within Seacombe Children's Centre in Wirral, Merseyside. The birth centre has 1 ensuite birthing room with a birthing pool. It is the base for the 'Highfield' maternity continuity of carer team who provide a continuity of carer community birth service to women and birthing people in Wirral, as well as staffing the birth centre. Between January and December 2022 there were 15 births at Seacombe Birth Centre and the Highfield team also supported 77 home births.

The local maternity population come from areas of higher levels of deprivation than the national average with 26% in the most deprived decile compared to 14% nationally. A higher proportion of mothers (91%) were White compared to the national averages.

The trust offers 4 birth options to women and birthing people including hospital setting, alongside midwifery led unit, freestanding midwifery led unit and home births.

Seacombe Birth Centre was registered with CQC in August 2022 and this is the first time this location has been inspected. We rated it as good because we rated safe and well-led as good.

Our findings

We also inspected 1 other maternity service run by Wirral University Teaching Hospital NHS Foundation Trust. Our reports are here:

Arrowe Park Hospital – https://www.cqc.org.uk/location/RBL14

How we carried out the inspection

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

We have not previously rated this service. We rated it as good 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.

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 had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. 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 services when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

There were gaps in the provision and checks of resuscitation equipment, although these were addressed during and shortly after our visit.

Is the service safe?

Good

We have not previously rated safe. We rated it as good.

Mandatory training

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

Most nursing and midwifery staff received and kept up-to-date with their mandatory training. Eighty-eight per cent of continuity of care midwifery staff had completed all 9 mandatory training courses. Managers monitored mandatory training and alerted staff when they needed to update their training.

Maternity

The service provided staff with multi-professional simulated obstetric emergency training. Eighty-six per cent of community midwives and 75% of continuity of carer midwives had completed Practical Obstetric Multi-Professional Training (PrOMPT). This training was themed around known risks and incidents within maternity services.

The birth centre had a pool in the birthing room. All staff had received up to date training in how to support a woman or birthing person in a pool evacuation emergency. Drills specifically relating to the birth centre started in 2023 additional to the annual updates relating to birth centre and home birth.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. Eighty-six per cent of midwives based at Seacombe Birth Centre had completed neo-natal life support. There was only 1 midwife who had not yet completed it, as they were a new starter, and they were booked onto training.

The trust employed a practice development midwife and carried out training needs analysis. This outlined training required for each role and frequency. A clinical preceptorship midwife supported band 5 newly qualified midwives through their preceptorship training programme.

Staff were supported to access and complete training by the practice development midwife. They organised regular skills and drills training based on themes and learning from incidents. Specialist midwives also provided short practice update sessions for staff.

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. Staff completed protecting vulnerable people (PVP) training level 4. In this service, level 4 PVP training equated to intercollegiate guidance level 3 safeguarding adults and children training. Training records showed staff had completed both level 3 safeguarding adults and level 3 safeguarding children training as set out in the trust's policy and in the intercollegiate guidelines. Ninety-three per cent of continuity of carer midwifery staff had completed this training.

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, for example by arranging interpreter services.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of developing individualised birth plans with relevant agencies and staff for women and birthing people where safeguarding risks had been identified.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service employed a safeguarding specialist midwife and a safeguarding team who staff could turn to when they had concerns. The safeguarding specialist midwife had won a national award for outstanding leadership in safeguarding. The safeguarding lead worked closely with other professionals in the local area and attended monthly multiagency meetings.

Maternity

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.

The birth centre was visibly clean and had suitable furnishings which were visibly clean and well-maintained. General cleaning was provided by the cleaners for the children's centre.

Staff cleaned equipment after contact with women and birthing people and labelled with green 'I am clean' stickers to indicate it was ready for use. Midwives were responsible for ensuring equipment was clean and ready for use and for cleaning the room and equipment after a birth. Maternity support workers carried out a weekly deep clean of the birthing room. This was monitored through monthly matron's audits.

Staff followed infection control principles including the use of personal protective equipment. Leaders completed regular infection prevention and control and hand hygiene audits. The most recent hand hygiene audit from March 2023 showed compliance was 100%.

Waste water from the birthing pool was discarded safely using a single use hose. Staff regularly checked pool cleanliness and there was standard operating procedure for cleaning the pool after use.

Staff followed policies and procedures for the transportation and disposal of soiled linen and placenta. Staff in the Highfield had a people safe device for lone working as an additional security measure following best practice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, there were gaps in the provision and checks of resuscitation equipment, although these were urgently addressed following our visit.

The environment was designed and fit for purpose. The design of the environment followed national guidance. The birth centre was fully secure with a monitored entry and exit system. Access to the birth centre during the day was through the reception for the children's centre, which was staffed. Out of hours midwives met women and birthing people at the centre and admitted them through either the main entrance or the side entrance direct into the birth centre. Staff followed a lone working policy when attending the centre out of hours and it was monitored by CCTV and a community patrol.

Staff carried out weekly safety checks of this specialist resuscitation equipment. This had changed in April from monthly checks and assessment visit by the trust resuscitation officer. However, during our inspection we found an out of date airway in the home birth resuscitation bag.

The service had suitable facilities to meet the needs of women and birthing people's families. T

There was access to a range of birthing equipment including birth balls, a birth stool and couches, as well as a birthing pool used for pain relief during delivery.

The standard operating procedures clearly outlined the arrangements for birth partners of women and birthing people to attend the birth and provide support. Following the birth, women and birthing people and their birth partners could

stay in the room until they were ready to go home. Midwives told us they did not place a time limit on this, but it was usually between 2 and 4 hours. There were no facilities for overnight stays or postnatal care at the birth centre. If a woman or birthing person required additional postnatal care, above that given by a community midwife, they would be transferred to the main maternity unit at Arrowe Park Hospital.

With the exception of the resuscitaire discussed below, the service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there was equipment to assist staff to evacuate a woman or birthing person from the pool in case of emergency. Staff completed skills and drills training on emergency pool evacuation.

Equipment maintenance was carried out by the trust's maintenance department, and we saw them on site during our inspection ensuring all relevant equipment had an up to date portable electrical appliance test.

The service had carried out ligature risk assessments of the environment in line with NHS England National Patient Safety Alert/2020/001/NHSPS.

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 clinical waste in bins in a locked compound outside the building while waiting for removal.

The birth centre was equipped with emergency equipment in line with best practice for home birth. This meant it did not have a resuscitaire. A resuscitaire is a large standing device used by midwives if a baby requires some additional support with their breathing when they are born. If a new-born required resuscitation, staff had access to a home birth resuscitation equipment bag. Following our inspection, the service confirmed they had sourced a resuscitaire for the birth centre. During our inspection, we saw a trolley set up with the equipment in preparation to be transferred to an appropriate flat stable surface should a new-born require resuscitation. Though staff told us they had been instructed to use a flat stable surface this was a risk as in an emergency midwives may transfer new-borns into the trolley to perform resuscitation and this was not a stable base on which to perform this. The service confirmed following the resuscitation officer's visit in April 2023, midwives had been instructed to no longer use the trolley for resuscitation. Following our inspection, they organised for it to be immediately removed and a resuscitation station to be installed.

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.

Risk was assessed at each maternity contact/appointment. We reviewed 3 maternity care records. In each record, risk factors had been defined and identified at the booking appointment, and risk assessments were completed at each maternity contact. This ensured women and birthing people were allocated to the right pathway so the correct team were involved in leading and planning their care.

The service had clear criteria for staff to assess if women and birthing people would be suitable to give birth at the birth centre. The standard operating procedure for the birth centre and 'guidelines for women who give birth outside of a hospital setting' gave clear guidance to staff which supported women and birthing people's choice and outlined the risk assessment process.

The service achieved 100% compliance with provision of one to one care in labour.

Maternity

There were clear criteria and processes to follow if a woman or birthing person required transfer to the obstetric-led unit at Arrowe Park Hospital. Transfer times were approximately 8 minutes but could be longer dependent on traffic. Women and birthing people were made aware of the transfer times to Arrowe Park Hospital and that this would take place by ambulance.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used a situation, background, assessment and recommendation (SBAR) tool to hand over care to staff at the obstetric led unit.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. This included the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff completed a quarterly audit of records to check they were fully completed and escalated appropriately. Audits for March and April 2023 scored 100%.

Audits were caried out to check risk assessments and safety checks were carried out. For example, matron's audits and team leader's audits were carried out monthly. Compliance rates were high and where issues were identified, action was taken to improve safety and compliance.

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. Specialist mental health midwives and support workers were part of the team. They attended multiagency meetings with mental health professionals and supported women and birthing people across a range of mental health needs.

The care record was held on a secure electronic system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information with multidisciplinary teams.

Staff completed new-born risk assessments using recognised tools and reviewed this regularly. New-born and infant physical examinations were carried out by the named community midwife at the postnatal visit following a birth at the birth centre.

Leaders monitored waiting times and made sure women and birthing people could access services when needed and received treatment within agreed timeframes and national targets. The birth centre and home birth service had remained open at all times between September 2022 and March 2023.

Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Maternity

The service had enough nursing and midwifery staff to keep women and babies safe. The birth centre was opened and staffed by a midwife when a woman or birthing person attended in labour. This was arranged directly with the home birth midwife and, out of hours, there was a home birth midwife on call. A second midwife would then attend from the 'Highfield' home birth team or, out of hours, the community on-call midwife would attend as second midwife.

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers needed for each shift in accordance with national guidance. The service had completed a maternity safe staffing review in March 2023 due to a decrease in births and increase in midwifery staffing. They had confirmed the staffing required to continue the roll out of continuity of carer. Managers reviewed staffing each day using a nationally recognised tool and had escalation processes, using redeployment of midwives, in line with NICE Guideline 4 Safe Midwifery staffing for maternity settings.

The service had no vacancies for midwives. In March 2023, the sickness absence rate for community midwifery staff was 0.9% and for continuity of carer midwives was 5.2%. The service did not use agency staff.

The service had specialist midwifery services and guidelines for the care of women with mental health problems, teenage pregnancies, substance misuse, bereavement services and infant feeding.

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

The service was delivered by midwives from the 'Highfield' continuity of carer team who also provided the home birth service. This meant all staff were experienced community and home birth midwives and maternity support workers.

Managers supported staff to develop through yearly, constructive appraisals of their work. The staff appraisal rate was at 100%. A practice development team supported midwives. They were responsible for ensuring the required levels of training attendance and competence was achieved. They had an escalation process for any staff who did not attend planned training. The practice development team had been recognised and won an award for the practical obstetric multi professional training delivered in 2022. Events were used within the training to provide practical learning opportunities.

There were a number of specialist midwives to support different aspects of the service such as fetal surveillance, mental health and bereavement. Managers made sure staff received any specialist training for their role. As well as supporting the staff, specialist midwifes also provided practice update training sessions for staff.

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 clinical records were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 3 sets of patient records, 3 of which were in the electronic system and 3 which were the linked paper records. We found the records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. To support this, the trust had recruited a midwife to lead on the digital role. There was an information technology (IT) steering group and transformation group with plans in place to upgrade IT systems and record keeping. Women and birthing people did not have direct access to their digital records, but development was underway for access to these to be provided from summer 2023. However, women and birthing people did have handheld notes.

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

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 to be administered during their admission. The medicines management process was clearly outlined in the standard operating procedure for the birth centre. Pharmacy cover was provided by the trust pharmacy department.

Staff completed medicines records accurately and kept them up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely although one oxygen cylinder was out of date for safe use. The birthing room where the medicines and intravenous fluids were stored was locked and could only be accessed by authorised staff. Staff explained a woman or birthing person would never be left unattended in the birthing room. Medicines for internal use were kept in a wall mounted locked medicines cupboard and there was a process to regularly change the digital code. Staff could access medicines from sealed home birth and anaphylaxis medicines kits.

Medicines were in date and stored at the correct temperature. Staff monitored and recorded room temperatures and knew to take action if there was variation. Medical gases were stored in line with risk assessments completed by the trust's fire safety and health and safety officer.

There were 2 cylinders of medical gases, one nitrous oxide and one oxygen, on a secure trolley for use in the birthing room. The oxygen cylinder was out of date for safe use. We escalated our concerns to leaders who took immediate action to remove and replace the out of date oxygen.

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 could describe what incidents were reportable and how to use the electronic reporting system. We reviewed an incident reported in the 3 months before inspection and found it to be reported correctly.

Maternity

The birth centre had no 'never' events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Weekly care improvement meetings took place to review incidents. Any identified learning or care improvements were shared with staff. Incident reporting was encouraged and used as an opportunity to learn and improve services.

Staff understood the duty of candour requirements. They were open and transparent and gave women and birthing people and families a full explanation if and when a notifiable safety incident occurred. 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. All incidents were reviewed by the clinical governance team and with a 10-day target to complete the duty of candour process and provide a written explanation.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations as our review of the rapid review for the 1 serious incident showed. In this example, managers offered an apology and explanation under duty of candour regulations.

Managers reviewed incidents potentially related to health inequalities through the incident investigation process. Leaders acknowledged this could be strengthened and improved and had plans to do this when changing to the new NHS patient safety incident response framework (PSIRF) for incident reporting.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with were aware of the recent serious incident and immediate learning and action taken. There was evidence changes had been made following feedback. For example, the resuscitation officer had carried out a full review and additional new-born resuscitation equipment had been ordered.

Is the service well-led?

Good

We have not previously rated well-led. We rated it as good.

Leadership

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

There was a clearly defined management and leadership structure for maternity services. The service was led by a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology – often referred to as 'the triumvirate'. The triumvirate were supported through clear professional arrangements. There was joint working between leaders within maternity, the wider trust, and external agencies and bodies to maximise care provision for women, birthing people and babies.

Maternity

Locally, staff at Seacombe Birth Centre were supported by the maternity matron and community midwifery team leaders.

The matron had lead responsibility for the birth centre and the consultant midwife supported the team by attending the centre and having a clinical presence regularly.

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

Both senior and local leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, matron and the head of midwifery. The matron and head of midwifery visited the birth centre on a regular basis. Staff spoke of how accessible and encouraging senior leaders and the executive team were.

The service was supported by maternity safety champions which includes the chief nurse and a non-executive directors.

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 and which included services delivered at Seacombe Birth Centre.

The maternity clinical service strategy for all maternity services was updated in April 2023 to reflect relevant learning from both the Ockenden Review and East Kent 'Reading the Signals' reports. This had been developed in consultation with staff at all levels in the women's and children's division and ensured it aligned with the trust's strategic objectives. Staff could explain the vision and what it meant for women and birthing people and babies.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. For example, one of the clinical service priorities was to 'provide seamless care working with our partners'. This described strategic partnerships and collaboration with other NHS providers, user groups and the Maternity Voices Partnership and universities. The strategy was underpinned by bespoke strategies for some areas such as the maternity digital strategy.

Leaders and staff understood and knew how to apply the strategy and monitor progress. The strategy included an accountability performance framework which included quarterly monitoring of progress toward achieving the strategic priorities.

Culture

Maternity

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.

Staff felt respected, supported, and valued**.** Staff were positive about the birth centre and the choice it offered women and birthing people. Staff told us they felt able to speak to leaders about difficulties and when issues arose.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture placing care at the heart of the service. They recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and described by staff we spoke with.

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. The 2022 maternity survey results showed the general level of care reported for this trust was positive.

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. All complaints and concerns were handled fairly, and the service initially used the most informal approach applicable to deal with complaints. Complaints and the response to complaints about all maternity services was a standard agenda item at monthly clinical governance meetings.

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

There had been no complaints received in the last 6 months about services at Seacombe Birth Centre

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. There was clear oversight of the service with appropriate lines of reporting to various meetings. For example, there were monthly clinical governance meetings which had oversight of all known or emerging risks. The governance process for the whole maternity service included reporting and oversight of service delivery and outcomes at Seacombe Birth Centre.

There was a clear line of communication between the birth centre, maternity service as a whole, and the trust board. A monthly maternity report was presented to the board of directors providing an update for quality and safety metrics within maternity services and identifying any key risks or required actions. Following any incidents or shortcomings in care or processes, action plans were developed with clear timescales and responsibilities.

Maternity

There was a learning culture and staff were encouraged to use the electronic reporting system to report any incidents so they could be analysed and used to learn and improve. A midwife leading on risk held weekly meetings to increase learning from incidents.

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

Staff followed up to date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were current and followed the latest guidance..

Management of risk, issues and performance

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

Maternity services participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Care improvement meetings were held weekly and reviewed incidents across the trust including maternity services.

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 maternity risk register, perinatal mortality review tool and Healthcare Safety Investigation Branch reports, clinical incidents and audits were a standing item at monthly clinical governance meetings for review and action planning. These were used to identify and manage known risks and were reviewed at monthly trust board meetings and presented to the board of directors every quarter by the director of midwifery.

There were plans to cope with unexpected events. Maternity services had a detailed local business continuity plan, which included Seacombe Birth Centre. Leaders worked closely with other local maternity departments to support each other when maternity services were busy.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Listening events and team meetings routinely took place and staff told us they were asked for their feedback and input.

Information Management

Maternity

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 had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations to compare performance. Clinical governance reports with statistics on quality, safety and performance were published and displayed in all the maternity areas for all staff to see.

Key performance indicators were displayed for review and managers could see other locations to compare performance. At the time of this inspection woman and birthing people did not have personal access to their clinical records through the hospital's system but changes planned to the IT system would enable this to happen. However, women and birthing people had maternity handheld notes**.** Development was underway for digital access to be provided from summer 2023.

The information systems were integrated and secure**.** Electronic records were protected by security access and only those staff with authorisation were able to see medical records.

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.

The voices of women and birthing people were considered within key decisions. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The trust were supportive of the MNVP, met with them frequently and involved them in key decisions affecting maternity services. This included, for example, the recruitment of new leaders.

The MNVP completed a '15 steps' visit of the birth centre in early 2023 and staff were able to describe the feedback and actions they were taking to make changes based on the recommendations. The MNVP report included consideration of the needs of women and birthing people with seldom heard voices.

The service held regular coffee mornings to promote the support available and build relationships between women, birthing people and the continuity of carer midwives.

Staff promoted choice for women and birthing people. Women and birthing people with complex social needs were not excluded from delivering in the birth centre, with protocols in place to ensure the involvement of specialist midwives and the consultant midwife as required.

Leaders understood the needs of the local population. Listening events took place within the local community and in multicultural centres to promote inclusion to all people.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The experience of woman and birthing people of using interpreter services was discussed and explored so

changes could be made to meet needs. Discussions were underway to further develop antenatal education into other languages and the translation of maternity information to include cultural differences. Staff also used a telephone interpretation service when required, which was available 24 hours a day, every day. Information on social media was also available in other languages.

Social media was used to engage with the local community. This included live streamed tours of the service and women and birthing people were able to make comments and ask questions. Changes were made in response to what people said or asked for. For example, the service had plans to change the décor to make it more welcoming in response to people's feedback. Important antenatal education messages such as 'what to do if fetal movements are reduced' were recorded by staff who could speak other languages and put on social media for people to access.

Listening events and staff meetings took place to engage with staff, communicate changes and listen to their views and experience. For example, listening events had covered topics such as staff work life balance and managing finances.

Learning, continuous improvement and innovation

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

The service was committed to improving by learning when things went well or not so well and promoted training and innovation. Learning was shared with staff through monthly clinical governance newsletters and staff social media platforms. These contained information about recognised risks and incidents; learning from care improvements meetings; complaints; staff and patient feedback; and nationally produced healthcare safety investigation branch reports. Staff were remined how to report incidents and about governance issues such as 'duty of candour.' The newsletter was also used to recognise staff achievements and good practice.

The trust was the only service within the local maternity services network to offer 4 birth choices to woman and birthing people.

The service had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

Funding had been secured for an application and new IT software to improve communication in other languages and antenatal education.

Midwifery mental health services were being devolved to provide increased support with anxiety and mental health wellbeing. For example, weekly 'singing mammas' groups were offered to antenatal woman (singing mammas groups are designed to improve mood, reduce stress and promote connections). Mental health midwives were attending training so hypnobirthing and a technique known as 'emotional freedom' could be offered. Virtual reality headsets were available for relaxation and meditation sessions.

The midwifery team had been awarded a team excellence award by the trust.

Maternity

Outstanding practice

The Maternity and Neonatal Voices Partnership (MNVP) Chair was well supported and received 16 hours per week funding. The relationship between the MNVP chair and leaders was strong and inclusive. The MNVP chair had access to leaders at all times and they responded quickly and efficiently to any concerns raised. The MNVP chair was involved in the recruitment of leaders and encouraged to attend regular meetings to feedback the voices of woman, birthing people and pregnant people. They were involved in a number of initiatives designed to reach out to all groups within the local community.

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:

Maternity

- The service should ensure staff carry out regular checks of specialist resuscitation equipment and that resuscitation equipment used is suitable and properly used.

Our inspection team

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