University Hospitals Coventry and Warwickshire NHS Trust

University Hospital

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 University Hospital

Good 

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

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

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well led key questions. We did not rate this location at this inspection. The previous rating of Good remains.

How we carried out the inspection

During our inspection of maternity services at University Hospital Coventry we spoke with 35 staff including leaders, obstetricians, midwives and maternity support workers.

We visited all areas of the unit including the antenatal clinic, antenatal ward, maternity triage, labour ward, birth centre, day assessment and postnatal ward We reviewed the environment, maternity policies while on site as well as reviewing 8 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 received 4 pieces of feedback and spoke with 7 women on the day of our inspection. We did not identify a theme or trend.

The trust provided maternity services at hospital and local community services and 5,267 babies were born in the trust during 2021.The hospital is also a tertiary referral centre for complex maternal and fetal indications.

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 overall. We rated it as good overall. Our rating of safe stayed the same. We rated safe as good. Our rating of well led improved. We rated well led as outstanding.

Staff had training in key skills, worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. People could access the service when they needed it and did not have to wait too long for treatment. They managed medicines well. The service managed safety incidents well and shared lessons learnt with the whole team and wider organisation.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Managers monitored the effectiveness of the service and made sure staff were competent. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were proud of the organisation as a place to work, spoke highly of the culture, and were clear about their roles and accountabilities. They focused on the needs of women, provided personalised care and were proactive in addressing health inequalities.

The leadership team understood and managed the priorities and issues the service faced and promoted a culture of multi-professional working and learning. There was a demonstrated commitment to best practice performance and a strong organisational commitment towards ensuring equality and inclusion across the service.

Leaders committed to high levels of constructive engagement with staff and people who used maternity services. Innovative approaches were used to gather feedback from service-users, and there was a demonstrated commitment to acting on feedback. Staff were committed to continually improving services and safe innovation was celebrated.

However:

They did not have a dedicated bereavement suite.

They did not always have enough midwifery and obstetric staff.

Is the service safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The design of training was responsive to staff needs and used bespoke programmes.

Maternity

Mandatory training was a training requirement determined by women's services through policy. It was compulsory for staff to attend all training relevant to their role. The compliance target was 100%, although the leadership team acknowledged there would be times when staff were unable to attend. For example, due to sickness. Overall maternity compliance was 90.3%

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training included but was not limited to fire safety, equality and diversity, information governance, responding to mental health needs and human factors.

All staff who cared for women in labour were required to complete annual training and competency assessments on cardiotocograph (CTG) interpretation and auscultation. It was mandatory for all obstetricians and midwives to complete an electronic fetal wellbeing training package annually. This included intrapartum CTG, cord blood gas, antenatal CTG and fetal physiology. Compliance was 93.7% for medical staff and 98.7% for midwives.

Staff would be referred to their line manager for a performance review and would not be permitted to care for women in labour or analyse CTG's, if they had not completed this training. The audit lead completed weekly audits of CTG reviews to determine compliance with policy and assess if the training was effective. Audit results were 100% for October 2022.

Learning to support fetal monitoring was also supported during weekly meetings to discuss recent cases of interest. This included the quality-of-care meetings and the clinical adverse review group. These sessions were minuted to include content and attendees.

Training was multidisciplinary during Practical Obstetric Multi-Professional Training (PROMPT), emergency skills and drills, CTG training and use of situation, background, assessment, recommendation (SBAR) handover tool. Human factors were included in all multidisciplinary training. PROMPT training was run from a simulation and development centre used for advanced interactive people training.

The service used bespoke programmes, combined with cutting-edge technology. For example, staff used an interactive screen, real-life scenarios using specially trained actors, virtual learning and bespoke artificial intelligence. Staff were able to practise clinical skills on an adult and baby advanced full body interactive simulators.

Training had only been paused for 3 months during the initial wave of the COVID-19 pandemic**.** Training was run in smaller groups since the pandemic as staff preferred this and engaged more effectively. Two training days had been secured to run multidisciplinary training for early 2023. This included a scenario related to a mental health crisis and involved community, accident and emergency, and ambulance staff.

The midwifery practice facilitator managed the allocation of staff training and maintained oversight. They met with the director of midwifery, deputy director of midwifery and modern matrons if compliance fell below 75%. The midwifery practice facilitator reported to the quality improvement patient safety (QIPS) and a monthly senior midwives meeting. The midwifery practice facilitator highlighted any staff training deficits, staff attendance, non-attendance, and any additional training that may be required. This group monitored clinical governance activities across maternity services. Information was disseminated at both trust and local level through the QIPS minutes and submitted together with the group risk register.

Maternity

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Maternity services worked in partnership with external agencies to keep women and babies safe.

Maternity staff received training specific for their role on how to recognise and report abuse. The service had a safeguarding team of 4 members of staff. This included a safeguarding lead midwife who was trained to safeguarding level 4. The safeguarding team trained staff, triaged referrals and were available to support staff with all safeguarding matters.

Midwives and obstetric staff were trained to safeguarding level 3. Overall compliance rates for women and children were 83% which was below the trust target of 95%. Maternity support workers and theatre staff were trained to safeguarding level 2. Safeguarding training was designed to reflect any current concerns that could be identified through an incident or complaint.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding team received an alert when a referral was made. The team reviewed all referrals to ensure that staff followed the correct process and were available for support. Annual leave was organised so that the team was always covered.

The safeguarding team provided safeguarding supervision to midwives to reduce risk whilst identifying needs. Community midwives received safeguarding supervision quarterly, the drug and alcohol midwife bi-monthly and the complex care team monthly. Other staff received safeguarding supervision as required.

Staff discussed safeguarding concerns at handovers in all clinical areas. The multidisciplinary meetings and sharing of information helped to ensure they interacted and coordinated their efforts to diagnose, treat, and plan for vulnerable women and families. Women were screened for safeguarding concerns and staff used the information to plan care and involve the right staff.

Staff did not record safeguarding concerns in women's handheld notes. This was because it could place women at risk. Staff recorded safeguarding concerns on electronic records, accessed only by those who needed it. A flag was raised on the woman's record to alert staff and ensured they were aware of the concerns. Safeguarding concerns were highlighted during handover using a handover tool.

We checked the notes of 5 pregnant women. Midwives routinely asked about their mental health. They asked about domestic abuse on more than 2 occasions in pregnancy and following birth. Maternity services monitored compliance with routine enquiry about domestic abuse through monthly audits. Midwives identified women in abusive relationships and supported them and their unborn baby to stay safe.

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. Community midwives referred women with mental health needs to the complex care team. The team included an advanced clinical practitioner midwife for perinatal mental health. They worked as part of a multi-disciplinary team and had one day per week protected to triage all referrals.

Maternity services had established one-stop clinic (INSPIRE clinic), for women who have suffered female genital mutilation. The clinic was a consultant-led service supported by specialist midwives who assessed and supported women to choose their preferred mode of birth, and make suitable adjustments, for example preparing for de-infibulation.

Staff gave examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensured 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 with protected characteristics.

The team had close involvement with drug and alcohol agencies and referral pathways. Staff could make direct referrals to support groups, for psychological and psychiatric reviews, and support. There was a specialist team of midwives who provided full case loading, and antenatal and postnatal continuity to vulnerable women. Each team-member had a different speciality. They worked directly with relevant external support agencies to provide streamlined and expert care. Vulnerable women had a designated named midwife and a higher level of continuity.

We reviewed several safeguarding incidents and saw immediate referrals and involvement with the safeguarding specialist midwife, the complex care team and multi-agency safeguarding hub. There was effective communication and clear and easy referral pathways to help keep women and babies safe.

Staff followed safe procedures for children visiting the wards. They followed the baby abduction policy and completed baby abduction drills every quarter. Additional security measures included an electronic baby tagging system.

Cleanliness, infection control and hygiene

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

Staff received mandatory training in infection prevention and control (IPC). As of September 2022, 96.6% of maternity staff had completed IPC training at Level 1, and 94% at level 2.

Staff followed infection control principles in the use of personal protective equipment (PPE). Staff used the right level of PPE, which was stored on wall mounted displays. Staff were bare below the elbow and hand sanitiser gels were available throughout the service. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks. Hand hygiene audit results were completed for all clinical areas. Results for hand hygiene audits were 100% on the postnatal ward and neonatal unit in September 2022, but not recorded for other clinical areas. IPC cannula audits were 97-100% across clinical areas and 95-99% for maximisers.

The premises were all visibly clean and cleaning records were up-to-date.We saw cleaners going about their duties throughout the day. There were suitable furnishings which were clean. We saw one armchair in triage which was torn, but otherwise furnishings were well-maintained. During the factual accuracy period the trust provided evidence that they were waiting for 54 armchairs to be delivered during the inspection period. The torn armchair in triage was replaced (along with other chairs in the unit), shortly after our inspection. This was part of a refurbishment programme.

The flooring in the clinical areas and associated corridors allowed for effective cleaning. The service performed enhanced and more frequent cleaning of all areas to prevent the spread of COVID-19, in line with national guidance.

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 service had suitable facilities to meet the needs of women and families. Departments within maternity services were secure. All areas were accessed through a secure intercom system. Visitors were asked to identify themselves before they were allowed entry.

Triage:

The triage area was open 24-hours a day. There was 1 triage room and 5 clinical rooms. Triage was for women from 20 weeks of pregnancy up to 6 weeks postnatally who were experiencing any problems related to pregnancy or following birth. Women also attended for early labour assessments. Fetal assessments were offered for reduced fetal movements, blood tests and other tests/reviews. Triage was situated next to labour ward so women could be transferred immediately if needed.

Antenatal Ward:

There were 4 bays which included 4 beds and ensuite facilities in each bay and 4 ensuite single rooms. Single rooms were prioritised according to clinical or psychological need. There were communal showers and a spacious dayroom for women to mobilise/relax in during the early stages of labour.

There was an infant milk kitchen on the antenatal ward. This included a milk-fridge for mothers to store expressed breast milk (EBM), for their baby. EBM was stored in sterile syringes or bottles and labelled. The name, hospital number, date and time expressed were written clearly on all labels. The milk-fridge was checked daily to ensure it was always locked, maintained at the correct temperature for safe storage of EBM and all EBM was labelled correctly and in-date.

Labour ward:

The service had enough suitable equipment to safely care for women and babies. The labour ward included a spacious, open reception area with comfortable seating for women and their birthing partners. There were two designated bays for women who had their labour induced. This included a bed in each bay. There was also a high-dependency bay which included two beds for women that needed close-monitoring during or after birth. There were 11 labour/birth rooms which all included ensuite facilities. One room included a pool for labour and birth. All rooms had facilities for women to aid labour. For example, birth balls, birthing stools and bean bags.

Each room included a computer so staff could maintain contemporaneous notes, without leaving women. All rooms included a cardiotocograph (CTG) and infant resuscitaire. Centralised CTG monitoring was also in place on labour ward. Staff had enough suitable equipment to care for high and low risk women during labour and birth.

There was no dedicated bereavement room for women and families who had experienced baby loss. There was a plan progressing through the private fund initiative (PFI) design and contracting process, but the Covid-19 pandemic and meeting the requirements of a PFI build had caused a delay. Maternity services had continued to liaise with service users to develop and co-design a new bereavement suite.

During the factual accuracy period the trust provided the designs and project plan for a dedicated bereavement suite. This included their interim arrangement to create a dedicated room by adapting an existing room within the birth centre. This had separate access to allow bereaved families access without entering labour ward. The room was in place and equipped with soft furnishings, a cold cot and ensuite facilities.

Lucina Birth Centre:

Maternity

The birth centre was designed in a homely, non-clinical way for women who were low risk. It had 5 rooms and 4 rooms included pools for women to labour/birth in. Rooms looked comfortable and spacious, with mood-lighting, battery operated lights and calming murals on their walls. There was a 'snug-room' for partners to relax in, and a spacious kitchen that was shared with staff. Women who were appropriately risk assessed were discharged home directly from Lucina.

There was a resuscitaire and emergency equipment situated within easy reach of each room. The staff had enough suitable equipment to care for low-risk women during labour and birth. The birth centre was situated next to the labour ward. Women could be quickly transferred if they developed complications. The neonatal intensive care unit and 2 theatres were near to labour ward. Mothers and babies could be quickly transferred in an emergency.

Post-Natal Ward:

There was a postnatal ward which included a transitional care area for babies that required more support. There were 6 ensuite rooms and 4 ensuite family rooms which were prioritised according to clinical and psychological need. The rooms were single and had additional spaces to enable partners to comfortably stay. There were also communal showers on the ward. The ward included a spacious, private room with sofas and armchairs for mothers to breastfeed.

Managers ensured all specialist equipment was serviced and calibrated. They maintained oversight of equipment to ensure it was safe and ready for use. We saw evidence of up-to-date safety testing. Records demonstrated staff carried out daily safety checks of specialist equipment.

There were resuscitation trollies in each clinical area, so all areas had easy access. All clinical areas had an emergency trolley for obstetric emergencies. We checked the emergency trolley in triage and the postnatal ward. There was evidence that daily checks had been completed to ensure all items were present and in-date.

Staff were required to check emergency equipment and infant resucitaires daily and replace any missing, expired or damaged items immediately. Audit results for October 2022 were 100% and used items were replaced. Equipment was available and safe for use.

Staff disposed of clinical waste safely. Waste was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Sharps bins were no more than three-quarters full. The date opened was stated on the bins and within three months of expiry in all areas. Arrangements for control of substances hazardous to health were adhered to.

Assessing and responding to patient risk

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

We reviewed 5 maternity care records. The lead professional was confirmed in all cases. Risk factors were highlighted. Women were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Maternity services audited 1% of notes monthly to determine compliance with risk assessments.

Maternity

Carbon monoxide screening was performed in each set of notes reviewed in line with best practice guidance. The service also audited compliance against this through monthly audit. Staff monitored the baby's growth, and accurately plotted this. Staff identified babies that were not meeting their growth potential, as they would be at higher risk of complications. The service reviewed the notes of all babies whose birth weight was the 3rd centile to determine if there had been any care issues during pregnancy.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. Staff completed and recorded MEOWS observations electronically. Management audited compliance with their MEOWS policy. Results showed observations were completed, concerns were escalated according to risk, and women were reviewed within expected timeframes.

Staff knew about and dealt with any specific risk issues. They applied the maternal sepsis screening tool and maternal Sepsis-Six pathway to pregnant women and women who had given birth 6 weeks earlier who showed signs of infection or whose observations were outside normal limits.

Staff knew about and dealt with any specific risk issues. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women having continuous cardiotocograph (CTG) during labour. The October 2022 audit showed clear interpretation and management plans following CTG in 100% of cases and staff completed 'fresh eyes' at each hourly assessment in 100% of cases. We also reviewed 4 CTGs and found fresh eyes were completed for all.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff also assessed all women at every contact to discuss any financial hardship and direct women and families to appropriate help as required. This included referring women and families to the vulnerable care team to determine their eligibility for food bank vouchers.

The newborn and infant physical examination (NIPE) screen was offered within 72 hours of birth and the service audited compliance to this. Results showed 94.7% of suitable babies had NIPE for August -October 2022.

The service provided transitional care for babies who required additional care and had also established a neonatal community outreach service (NCOS) in September 2022. The NCOS had completed 2000 home visits and supported 100 babies to be discharged early to be reunited with their families.

Staff booked interpreters for planned face-to-face appointments. They used a language interpreting telephone service which could be available 24 hours-a-day for unplanned contacts. If there was an emergency involving a non- English-speaking woman, they communicated a 'shout-out' across the trust to determine if any staff member spoke the required language.

Women who chose to give birth outside of guidelines were supported. These women were offered an appointment with the consultant midwife and/or an appointment with a consultant obstetrician. The consultant midwife discussed the woman's decision, and they agreed a birth plan together. The aim was to support women's choice and to ensure the birth was as safe as possible. The consultant midwife and on-call team were available to support midwives caring for women outside of guidance. Midwives told us the teams worked together well to support informed choice. Midwives also felt well informed and well supported in these situations.

Maternity

Managers monitored waiting times and made sure women could access emergency care and treatment when needed and within agreed timeframes and national targets. All women who attended triage were RAG (red, amber or green) rated, dependant on their clinical need and urgency. Staff contacted the obstetric on-call team if a woman needed a review.

All staff received training in an evidence-based triage tool and system. Staff had to complete and demonstrate specific competencies to work in triage. There was a dedicated phone in triage to take calls from ambulances.

The service completed monthly audits to determine if women were categorised correctly, seen and treated according to their clinical need and the amount of time women spent in triage. Eighty percent of women were seen within 30 minutes of arrival and 100% were RAG rated correctly in September 2022. However, 6 out of 16 women did not have an obstetric review within the correct time frame, and the reasons for this were not included with the audit results.

Women who were booked for elective caesarean sections completed a lateral flow test 48 hours in advance. They also completed screening for methicillin-resistant staphylococcus aureus. The service made sure it was safe for women to proceed with their planned date.

Staff used a nationally recognised handover tool known as SBAR for handover(s) of care. SBAR 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. The SBAR was also used for escalating women that required further review. Compliance was 71.5% across all areas. It was not clear if any action(s) had been implemented to improve results.

Shift changes and handovers included all necessary information to keep women and babies safe. Safety huddles occurred three times a day and were multidisciplinary. The maternity bleep holder and director of midwifery attended all huddles to help ensure they had oversight of the unit.

Midwifery Staffing

The service did not always have enough maternity staff. Staff had the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction. 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 did not always have enough nursing and midwifery staff. Recruitment and retention had been challenging since the start of the COVID-19 pandemic. There were 19 whole time equivalent (WTE) vacancies when we visited. There had been a very recent recruitment event and managers were in the process of filling the vacancies with international staff and return-to-practice midwives. There were 38 WTE midwives in the recruitment pipeline and all due to start by February/March 2023.

Staffing levels did not always match the planned numbers. There should have been 10 midwives plus a labour ward coordinator on the labour ward, on the day of our visit. There were 8, plus the labour ward coordinator. The labour ward coordinator was supernumerary, and managers monitored compliance to this.

Maternity

Staffing rosters were published 6 weeks in advance, signed off by matrons and authorised by the director or deputy director of midwifery (DoM). Managers aimed to cover unexpected staffing shortages by redeployment of staff to areas most in need. The trust employed bank staff who were used by the maternity service if this was not possible. The continuity-of-care teams had been suspended until staffing levels had improved.

Maternity services had a comprehensive escalation policy, with clear escalation pathways for hospital and community staff. There was a midwifery on-call rota for labour ward. The midwife was asked to attend during times of excessive workload. There were always 3 community midwives on call out-of-hours. On-call midwives attended for a maximum period of 4 hours. If support was still needed, the 2nd on-call midwife was called. The system was developed in response to staff feedback.

Maternity staffing levels were discussed at all safety huddles. Additional safety huddles were called as required. Staff discussed risk ratings for staffing and acuity and admissions and transfers for midwifery and neonatal services.

The trust had completed a recruitment and retention plan in response to staff vacancies. Safe staffing in maternity was regularly reported to the quarterly public trust board meeting. This included a review of their maternity support worker establishment, roles, and banding. This was aligned to the Birthrate plus recommendations for midwife to support worker ratio to help improve safety and the quality of experience for women and families.

There was a recruitment and retention midwife who took part in the national retention toolkit programme. The self-assessment toolkit enabled maternity services to undertake a self-assessment against the seven elements that supported staff to deliver high quality care, enhance job satisfaction and support the retention of midwives.

Maternity services had established a workforce planning, recruitment and retention group to review and address the staffing challenges. The group met bi-weekly to review progress and update trajectories and modified the approach as indicated.

The group had implemented several changes to address the staffing shortfall. This included an enhanced bank rate which had been effective in helping to cover some vacant shifts. Specialist midwives and ward managers were also rostered to support essential shifts that were vacant. Maternity services had introduced a ‘matron of the day’ to strengthen staffing oversight. They linked closely into established safer staffing /escalation processes within the trust.

Maternity services employed a band 3 induction of labour coordinator. They called women booked for induction of labour (IOL) to ensure they were prepared before attending and knew what to expect. They advised if they needed to delay attending due to high acuity/insufficient staffing, and kept women updated with regular calls. There was also a live advert for an IOL midwife to work closely with the IOL coordinator. Their main remit would be to improve the induction of labour process and flow throughout the maternity department.

Managers ensured women received one-to-one-care in labour. One hundred percent of women had one-to-one care in labour for the previous reporting period for 2022. The labour ward coordinator was supernumerary to maintain a helicopter view of the area. This had been maintained at 98% for the same reporting period. The managers monitored compliance to the supernumerary status of the coordinator and one-one care in labour to keep women and babies safe.

Maternity

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline NG4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. There were 329 red flag incidents in the previous 6 months. Eighty-six percent were due to a delay between admission and starting the induction of labour process. No red flags were due to a delay in an emergency caesarean section.

Red flags were captured on the acuity tool and reported on the maternity dashboard. All red flags were reviewed for any harm and reported to trust board within the maternity safety plan report. The events were shared with the manager of the day for the risk team for women and children's services and the trust site manager. Any unresolved staffing gaps were escalated regionally. There had been no adverse outcomes or clinical harm as a result of the red flag events.

There was dedicated midwifery staff to manage triage calls. The phone-line was managed 24-hours a day in-line with national guidance (NICE, 2017), and 2 midwives were allocated to take calls during their busiest period, between 11am and 5pm.

Women who had suffered a baby loss were cared for by labour ward staff, supported by the bereavement team. The bereavement lead midwife managed the service, led on bereavement training, and supported staff to care for bereaved families. The service has 4 bereavement midwives and support from the trust chaplaincy team. The team had received several DAISY award nominations from families, and awards for staff caring for bereaved women.

There was a preceptorship programme for newly qualified midwives to progress from a band 5 to band 6 grade. The programme adopted a blended learning approach of study days, electronic learning modules and reflective sessions. The learning supported the transition from student to qualified practitioner. There was also a placement midwife for students, who provided pastoral support, funded by the link-university.

The professional midwifery advocates (PMAs) were responsible for implementing the A-EQUIP Model (advocating and educating for quality improvement). This model aimed to support midwives through a process of restorative clinical supervision and personal action plan, for quality improvement. Midwives had access to support from their PMAs and were encouraged to meet them when training needs were identified.

Midwifery bank staff received a full induction and had to complete all mandatory training. New starters had to complete an induction programme. Their competencies were assessed and signed off during this period. Managers ensured staff had the clinical skills to keep women safe.

Managers supported staff to develop through yearly, constructive appraisals of their work. We were given examples of how staff had been supported to develop through training, attending conferences, support and supervision. Staff told us managers and the DoM were very supportive of their development and the DoM often identified developmental opportunities and encouraged staff to apply. Staff were given opportunities for development as part of their annual appraisal. Their compliance for staff appraisals was 89.6% at the time of our visit.

Midwives received the required specialist training to fulfil their role. For example, midwives who provided high-dependency care completed specialist training as recommended in Care of the critically ill woman in childbirth; enhanced maternal care (Royal College of Anaesthetists 2018). Labour ward coordinators received an orientation package which included specific training and mentoring to support them. They were also trained to complete 'hot' debriefs to support staff immediately following incidents.

Sonographer midwives completed a postgraduate certificate, diploma or degree in ultrasound scanning before being accredited as competent.

Medical staffing

The service did not always have enough medical staff. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. Medical staff had the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff and used locums to backfill gaps in cover. This included 2 locums which they used regularly. Consultants covered labour ward for 96 hours per week and were on site from 8.30am to 10pm, seven days a week. The service was not adhering to recommendations outlined in Safer Childbirth (2007) by providing 168 hours of consultant presence by 2008. However, they were complying with the Royal College of Obstetrics and Gynaecology Standards for Maternity Care (2016). The service mitigated the risk of no consultant cover overnight by providing overnight on-call cover with a journey time of 30 minutes or less to site.

During weekdays the on-call consultant provided additional assistance to the labour ward team. The workload was assessed at the medical handover at 5.30 pm and if needed, the labour ward consultant supported the on-call consultant and did not leave until safe to do so. On-call teams kept the same doctors which helped to maintain continuity.

The escalation policy included guidance regarding medical staffing and support about staffing levels and when staff must contact the consultant and ask them to attend. The consultant obstetrician had a designated bleep to alert them of any obstetric emergencies and was required to attend all obstetric emergencies.

Consultants led 3 multidisciplinary rounds on labour ward throughout the day where they reviewed and planned women's care and shared learning with the rest of the team.

There was only consultant cover for the wards 3 days per week. A senior registrar led on daily ward rounds on the antenatal ward. However, unexpected and high-risk admissions were reviewed by an obstetric consultant, who outlined their plan of care. There was an assurance mechanism in place regarding the competence of middle grade doctors in the absence of consultant presence.

The triage service was staffed by the labour ward team. A dedicated SHO/ junior registrar provided cover across triage and fetal wellbeing 4 days a week, during daylight hours. The remaining 3 weekdays were covered by the labour ward team. During the factual accuracy period the trust provided additional evidence to confirm they were actively recruiting to provide dedicated obstetric cover 5 days/week.

The service had 3 midwifery advanced clinical practitioners who were all independent prescribers. They carried a bleep and could undertake assessments for women who were risk assessed for medical review. They could discuss plans to admit/discharge women with the consultant and although they were not available during night hours, they were an addition to the obstetric team and provided support during the day.

In addition, the service had secured 3 additional Health Education England medical trainees from September 2023. It was anticipated that this would allow a postgraduate doctor working at SHO/ junior registrar level to be based in triage 5 days/week with potential to increase to 7-day coverage.

Maternity

All scans needed an obstetric review on triage or the weekly scan review clinic that was led by a senior obstetric registrar. This included normal scans which affected the flow for women and put unnecessary pressure on maternity services. During the factual accuracy process the trust provided a recently signed-off clinical guideline to support midwife sonographers to sign off normal scans without the need for obstetric review.

There were sickness absences and there was also a recruitment plan for an additional consultant. The service was actively recruiting to fill vacancies. There were fortnightly international recruitment meetings with a medical recruitment agency and the trust collaborated with partners to maintain momentum with their international recruitment pipeline.

Obstetric staff received three days protected induction. This included PROMPT, skills and drills, fetal monitoring training, and an assessment, which they had to pass. They attended mandatory external advanced training sessions and had annual reviews by their educational supervisor and college tutor. Obstetricians received both theoretical and practical training in performing fetal blood sampling during induction. Their competencies were assessed during their progression through their career pathway.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Ninety-two percent of obstetric and neonatal staff had an appraisal within the previous 12 months.

The clinical director promoted well-being and support for exception reporting. Staff told us consultants were visible, available, and supportive. Junior staff had protected time included in their working hours for learning. This included time for clinical governance. There was an emphasis on learning and improvement and supporting colleagues.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely, and easily available to all staff providing care. Women could assess their notes online and contribute to their care planning.

The service had a digital midwife who managed a team of 5 members of staff in the maternity information team. The digital midwives had led on the roll-out of their digital system. All pregnant women could register to access their maternity notes online. The web-based portal allowed them to view their notes securely and until they were discharged from maternity care.

Pregnant women could record a personalised care plan, record questions for future appointments, access leaflets and information, add their maternity exemption certificate and MAT B1. They could also add notifications. For example, if they changed their GP or moved out-of-area. There was also a facility to be remotely monitored, if suitable.

The system was launched in November 2020. It had many advantages over paper record which included enhanced documentation, information reporting and increased communication with women. The system improved safety and was more efficient for staff. In addition, maternity services lent handheld electronic devices to women who were digitally excluded. Staff ensured all women had equal access to this facility.

Midwives received annual training on record keeping. Staff kept records of women's care and treatment securely. We checked 5 sets of maternity notes and saw they were completed in full. Notes were electronic, this meant the date and

time of entries were populated automatically. Managers completed and monitored compliance to the documentation policy through monthly audit. This was to ensure documentation adhered to nursing and midwifery and general medical council standards and reflected local policy. Recent audit showed care was delivered as outlined in plans. For example, 100% of fluid balance charts were accurate and completed for the previous 6 months.

Discharge information was recorded electronically and triggered an alert to the relevant GP and community midwives.

Medicines

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

Midwives received mandatory training in medicine management annually. The maternity service had an up-to-date policy which included midwifery exemptions. This was to provide support and guidance to midwives in the supply and administration of drugs that are listed under midwives' exemptions as specified in the Human Medicines Regulations 2012. Managers discussed this policy as part of midwives' annual appraisal. They ensured staff had read and understood the policy.

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicine records accurately and kept them up-to-date. We reviewed the medicine records for 5 women and 1 baby. Prescriptions were named, dated, timed, and included relevant information such as allergies, weight and route of administration.

Medicines were stored within automated medicine cabinets with biometric access. Medicines security risk assessments were completed and reviewed annually by ward and department managers. Any drug security breaches would be discussed at ward and department level including quality improvement and patient safety meetings.

Records for checking controlled drugs demonstrated that the medicine policy was followed. Records showed two staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

Clinical fridge temperatures were maintained between a minimum and maximum recommended temperature. They were checked daily to ensure required medication was stored at the correct temperature to maintain drug efficacy. Compliance to their medicine management policy was 96% between April and September 2022. However, the ambient room temperature was not monitored in areas where medication was required to be stored at room temperature. The service could not be assured medicines were always stored at the recommended temperatures.

During the factual accuracy process the trust providing supporting evidence to confirm that they immediately purchased thermometers for areas where medication was required to be stored at room temperature. They also implemented an ambient temperature monitoring checklist.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well-ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Incidents

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

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The patient safety response (PSR) was initiated if an incident was identified that had potential to cause moderate harm, severe harm, death, or was a suspected serious incident or Never Event. The PSR process was embedded across the trust and included the maternity service.

The PSR consisted of a senior doctor, senior nurse, and a member of the patient safety team. The purpose was to ensure the patient and clinical area were safe and staff were appropriately supported. The PSR ensured the duty of candour (DoC) process had commenced, facts were gathered, an appropriate investigation was underway, and any immediate learning was identified, actioned, and shared trust-wide where required.

The Perinatal Mortality Review Tool was embedded throughout the service. This ensured external staff with expertise were involved in investigations. Women were involved in investigations and had a point of contact, so they had continuity and support throughout the process.

Data on incidents was reviewed at the quality improvement and patient safety (QIPS) meeting in conjunction with the patient safety team. Themes and trends within the data were analysed. Action plans were devised if concerns were identified. The process for investigating and managing incidents was based on learning and improvement, not on apportioning blame.

Staff knew what incidents to report and how to report them. There was a clear process which staff understood and followed. The trust used an electronic reporting system which all grades of staff had access to. Training in incident management was provided at induction and during regular trust training sessions. Managers were provided with training in the use of incident reporting software prior to being granted access.

Staff received a hot debrief immediately following an incident. Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event and has the advantage of earlier intervention, improved participation, and improved recall of events. Managers debriefed and supported staff after any serious incident. We were given several examples of how staff had been supported. The service had access to a clinical psychologist, a chaplain, a professional midwifery advocate or chosen manager.

Managers also considered the need for an evidence-based approach using a trauma risk management (TRIM) methodology. This helped to identify risks for people who may suffer poor mental health following a traumatic experience. We saw that 41 members of staff had a TRIM referral following a recent serious incident. Staff with different roles and grades gave recent examples of how they had felt well supported following a clinical incident. Psychological support and safety were routinely considered as part of investigations into clinical incidents. Staff also had the opportunity to escalate a ‘stop-the-line’ if a process was identified as unsafe. This helped to avoid reoccurrence until mitigations were put in place.

Staff received feedback following incident investigations and themes from incidents were shared. Learning from incidents was shared at handovers and huddles in all clinical areas. Safety messages from the chief medical officer were disseminated weekly to staff trust-wide and discussed at safety huddles.

Staff understood the DoC. Leaders monitored the compliance with DoC through audit and results showed they were open and transparent and gave women and families a full explanation when things went wrong.

Maternity

Is the service well-led?

Outstanding ☆ ↑

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They promoted collective leadership and a culture of multi-professional working and learning.

There was a clearly defined management and leadership structure in place. The director of midwifery (DoM) was supported by the deputy director of midwifery, a consultant midwife, a team of modern matrons, lead midwives and 3 advanced clinical practitioners. There was joint working between leaders within maternity, the rest of the trust, and external agencies and bodies to maximise care provision for women and babies.

In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. Monthly maternity performance indicators formed part of the trusts integrated performance report which was reviewed by the board. The DoM attended board meetings and presented any midwifery papers/reports. This included a quarterly update on their Ockenden gap analysis and progress. Parents stories were also presented to help the board understand their lived experience. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies.

There was a virtual local maternity and neonatal system meeting that followed every midday huddle. The DoM, matrons, labour ward coordinator, ward managers, neonatal and obstetric consultants participated in this. Risks for staffing, acuity, admissions, and possible transfers across the region were discussed.

The trust agreed to support an increase in the number of midwifery students on the pre-registration midwifery course at Coventry University from 23 to 45. A practice placement midwife had been funded for 2 years to support the up lift. Health Education England had also funded a 6-month secondment to introduce learning zones on the antenatal and postnatal wards.

The increased pre-registration programme had been identified as a best-practice- model and shared within Future Platforms by NHS Improvement and NHS England in February 2022.

In addition, maternity services had developed a service level agreement for the shortened 18-month programme with Birmingham City University, and one student was currently on placement. The trust had approached the university and requested an additional 4 placements as part of the national recruitment strategy. The trust planned to bid for an additional 5 per educational year.

Other measures included the recruitment of additional midwifery support roles, the exploration of apprentiship programmes and modular development options for training with education providers/ practice educations experts to support return- to- practice midwives.

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The leadership team were focused on the retention of existing and new staff. The Midlands region had developed a retention toolkit which managers were piloting in maternity services. The leadership team continued to develop developmental/training opportunities to maternity staff. This included a sustainable career pathway and framework that supported talent mapping and succession planning. The trust was recruiting a stakeholder engagement coordinator, to support the equity work. They were focused on leadership for successful retention and reviewed career pathways and opportunities for staff.

The leadership team prioritised the safety of their maternity service. The trust had 3 board level champions who met with the DoM for weekly updates regarding maternity services. They completed regular walk-arounds, scrutinised data and reports. They were knowledgeable about the service, and proactive about holding the leadership team to account. Staff found them approachable, and keen to hear their views and experiences, to drive improvement.

The chief nursing officer completed 'leadership rounding' with staff across maternity services. They met quarterly with community midwives as part of their scheduled update programme. There was a bi-weekly maternity safety production board attended by the chief nursing officer, non-executive director, maternity safety champions, senior clinical leadership team and wider clinical body. They focused on progressing the key quality metrics for maternity services.

The DoM and clinical director completed daily walk rounds to ensure they were visible and could maintain a good understanding of clinical activity. The DoM completed their daily walk around at 6.30 am so that they could check-in with night staff and ensure they did not feel neglected by managers. Staff told us senior managers were visible and available and spoke highly of their support and clinical expertise. The DoM and clinical director also worked clinically to create conditions for high levels of staff engagement in supportive, appreciative environments.

The DoM and chief nursing officer were having reverse mentoring. The reverse mentoring paired senior white leaders (mentees), with black and minority ethnic staff (mentors). This was to help them explore their mentees' practices in relation to equality, diversity, and inclusion. A leaders' program was being developed to support ethnic groups to become leaders. The leadership team were committed to recruiting new staff to reflect the demographics of the local community. Diversity and inclusion were treated with high importance across maternity services.

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 strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

Women and children's services had a strategic plan for 2020-25. The strategic plan covered the whole of women and children's clinical group. Their vision was to provide an accessible, specialized service, that was patient driven and provided high-quality, safe care, to women and children across their local footprint.

Four goals underpinned the vision. Goals included developing a partnership approach across the local maternity system (LMS), playing a leading role in the development of a single managed service, delivering tertiary gynaecological oncology services, and developing a highly skilled specialised service.

There were several projects underway to support the strategy over the next 5 years. Some of these projects included:

- Sustained focus on safety

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- Establish neonatal outreach service
- Establish a dedicated bereavement suite for women who suffered a baby loss
- Centralised Gynae-Oncology multidisciplinary teams
- Leadership development and succession planning
- Integrate LMS and sustainability and transformation plan workstreams (integrating maternity and paediatric service design)
- Increase physical footprint to support recovery space for ambulatory services
- Scanning and diagnostics provided more accessibly in the community

Culture

Staff were proud of the organisation as a place to work and spoke highly of the culture. There was strong collaboration, team-working and support across all functions. There was a common focus on improving the quality and sustainability of care and people's experiences. The leadership team showed a strong organisational commitment towards ensuring that there was equality and inclusion across the service.

The trust was the first university hospital in the UK to be awarded the internationally acclaimed Pathway to Excellence designation. This included maternity services who demonstrated their commitment to establishing a healthy workplace for staff and embedding a culture of positive practice and personalised care.

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. They strived to ensure the tone of meetings was about promoting openness and honesty to seek learning and assure themselves that learning was embedded.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff were proud to work for the trust and felt valued and respected by management. Staff described healthy working relationships where they felt respected and able to raise concerns without fear. The culture was one of learning and focused on improvement, not blame.

Maternity services worked in collaboration with MAMTA to improve child and maternal health outcomes for black and minority women (BME) in Coventry. MAMTA means motherly love in many South Asian languages and is a health project for black and minority ethnic women. MAMTA was established in Coventry in 2001. This was in response to poor child and maternal health outcomes within BME groups in Coventry, compared with the overall population.

Midwives worked jointly with peer workers from MAMTA to support antenatal appointments and antenatal classes in the language of the individual/group. MAMTA reinforced key health messages and were able to link women and families to other vital support and services, depending on need.

The outreach midwife for drug and alcohol misuse and the vulnerable caseload team held antenatal appointments and drop-in sessions from a street-based outreach service for women working on the street. This service was run from a location that sex workers trusted and attended for other reasons. Running antenatal appointments and drop-in sessions from the same venue had improved engagement and we saw evidence of positive feedback from women.

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Addressing equality and inclusion and health inequalities had become regular agenda items at meetings between maternity services and their maternity voices partnership. The service used other more suitable venues to engage with women who could be harder to reach. For example, community and religious centers. The service was recruiting a stakeholder engagement coordinator, to support the service equality work.

Maternity services had ring-fenced funding to recruit international midwifes. The leadership team felt this would help their workforce reflected the local community as well as learning from midwives trained in other countries.

Professional midwifery advocates (PMAs) supported restorative practice, service, and staff development. The lead PMA was appointed in 2021 and led on the civility and respect toolkit survey. The toolkit was a quick-reference guide of best practice that they used to grow that culture by embedding civility within maternity units. The exercise was completed in February 2022, with restorative meetings, feedback to staff and drop-in sessions to help improve health and wellbeing.

The trust employed 1 Freedom to Speak up Guardian (FTSuG), and 14 Freedom to Speak up Ambassadors, which included a midwife. They supported staff who wished to speak up about a concern or issue. Staff were able to raise concerns through the trust Speak Up app. The app was a recently launched initiative. It allowed staff to make direct contact with the FTSuG to raise a concern confidentially and anonymously should they wish.

Managers investigated complaints and identified themes. Complaints were fed back to individuals to help them understand the parent's perception of their care. They were presented at maternity study days to share learning. Themes were shared at handovers, huddles, on staff notice boards, their governance newsletter, and by email. Complaints were presented to monthly divisional governance and directorate risk meetings and could be used to inform training and skills and drills.

The service had implemented a personalised care guideline to keep staff focused on individualised care for individual women and their families. Staff centred on the woman, her baby and her family, based around their needs and their decisions. Women were offered genuine choice, informed by unbiased information.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations. Governance arrangements were proactively reviewed and reflected best practice. Maternity services adopted a systematic approach by working with other organisations to improve care outcomes more widely. 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.

The trust received notification in February 2022 that maternity services were successful in achieving all 10 safety standards for the maternity incentive scheme (MIC), for 2020/21. Maternity services had a MIC and Ockenden assurance lead midwife. The lead midwife managed the maternity audit rolling-programme for 2022-2023. The quality officer maintained oversight of the programme and each audit had an allocated lead.

Maternity services were on track with all measures outlined within the year-4 MIC and held weekly multi-disciplinary team mortality review meetings. Parental views and feedback were included for all cases. Any questions that parents had regarding care were incorporated into the review to ensure they received timely and full feedback.

An audit plan had been developed to continually monitor and identify areas to improve service outcomes. Maternity services participated in national audits. For example, national pregnancy in diabetes audit. They participated in the

national confidential Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK. They also completed locally approved audits. For example, the service reviewed 1% of notes per month to ensure that women had a risk assessment at each contact in pregnancy and 1% of monthly notes were reviewed to determine if women with complex medical needs had a named consultant as their lead professional.

Audit results consistently met compliance targets. For example, 100 % of smokers were referred to smoking cessation support at booking. Monthly compliance for WHO surgical checklist was 100% for August- September 2022. The audit lead also completed random checks. Audit results were shared and discussed during weekly theatre huddles. An imminent 2-week observational phase of the current state was due with a view to develop a plan for improvements.

Audit meetings were followed by quality, improvement and patient safety meetings (QIPS). QUIPs were held 10 times a year and chaired by the clinical director. QUIPs were always clinically led as these meetings were used to provide oversight of the service.

A dashboard of compliance had been developed which presented specific compliance data. This clearly identified the network compliance and provided a further breakdown of individual trust performance. This was developed to identify areas of good practice and areas for improvement.

The Chief Quality Officer had operational responsibility to ensure that patient safety incident investigations were fair and equitable, the cause of harm was identified, and learning was disseminated across the organisation.

In the event of a potential/serious incident the chief quality officer would oversee the investigation process (as chair of the serious incident group) and ensured that relevant details were reported to the patient safety and effectiveness committee, chief officers' group and where relevant, integrated care board.

All learning from incidents and healthcare safety investigation branch recommendations were shared across the service. This included the weekly quality of care multi-professional learning meetings, weekly departmental training sessions and monthly quality meetings to inform practice. Departmental meetings were held online to maximise the number of staff who could join.

Quarterly reports were presented to the trust board and monthly to the local maternity and neonatal system for oversight and assurance. The leadership team completed an appreciative enquiry using the national maternity self-assessment tool and developed an action plan to address potential gaps and for ongoing assurance.

Governance boards were clearly visible in every clinical area. These were updated by the midwife in charge. There was a numerical overview for the week which included the number of open incidents, the number of incidents reported by staff and number of formal complaints. The top 3 risks logged on the maternity services risk register were highlighted. Brief details of the 3 most recent complaints were listed including actions to prevent similar issues. For example, the service had updated their induction of labour guideline in response to a complaint regarding delay(s) and a review of the local process.

Recent compliments were also highlighted to help staff feel valued and recognise what was going well. A message of the week was included to reflect learning from any recent incidents or serious incidents.

There was a section on the board for staff to highlight any concerns, ideas for improvement or positive practice. The board also included current training compliance for key training such as emergency skills and drills and fetal wellbeing. Managers ensured staff were informed and up-to-date about key information, shared learning promptly and gave staff opportunities to contribute.

All staff were encouraged to attend, participate and reflect on real-time events at quality-of-care meetings, clinical adverse event meetings and emergency caesarean section reviews. The risk team included the clinical negligence scheme for trusts and Ockenden assurance. The committee ensured that management responded to findings and issues identified by audit activity.

The maternity forum met monthly and reviewed guidelines/polices that needed updating. Updated guidelines were communicated to all maternity staff in a structured manner. New or updated user-leaflets were also reviewed, updated and disseminated. The forum had a process to maintain oversight of guidelines/policy reviews to ensure they were up-to-date and reflected best practice and national guidance.

The trust had the only Level 2 and 3 neonatal unit within the local maternity and neonatal system (LMNS). The LMNS is a partnership between maternity, neonatal services, and key local stakeholders. The maternity team worked hard to ensure all women with threatened pre-term labour less than 32 weeks were received. Any women who were unable to be accepted due to capacity on the labour ward or neonatal unit were discussed as part of the bi-weekly maternity safety champion meetings for oversight and assurance.

The term re-admission rate for maternity services was 2.9% and consistently below the national reported average of 5%. The avoiding term admission into neonatal unit (ATAIN) meetings occurred bi-weekly. All unplanned term admissions were reviewed as part of a multi-professional review. This was to determine whether the admission was avoidable or not. Any learning was shared within an action plan and disseminated to staff in a newsletter.

Formal complaints were investigated by the quality team who worked in partnership with the legal team, as and when required. Any themes from complaints were weaved into training.

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. There was a demonstrated commitment to best practice performance and risk management systems and processes.

A risk register was used to identify and manage risks to the service and included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included. The highest risk for maternity services was the inability to achieve the national recommended midwifery staffing in accordance with their Birthrate Plus assessment.

The requirement for a dedicated bereavement suite was highlighted on the service risk register. It was a priority for the service to deliver as women and families who experienced bereavement could not receive care and support in an environment considered to be most conducive to meet their needs. The risk was presented to the trust risk committee (chaired by the CEO and attended by the executive team). This ensured executive oversight.

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The risk manager for women and children was the named patient safety specialist and managed the risk team for women and children services. The risk team included the clinical negligence scheme for trusts and Ockenden assurance lead midwife, maternity risk officer, maternity administrator, practice facilitator midwife and clinical practice facilitator midwife. The team delivered annual training on risk management to all midwives and supported maternity staff with all matters relating to risk management.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings.

Mandatory training was concerned with minimising risk, promoting quality and ensuring the trust met external frameworks; for example, the Maternity Incentive Scheme, Ockenden (2021, 2022) Immediate and Essential Safety Actions and professional registration for midwives to ensure they complied with statutory requirements.

The trust monitored the number of incidents and serious incidents that staff reported monthly. Governance and risk leads joined up with leads across the local maternity and neonatal system to identify learning from incidents across the system.

Staff were open and transparent and gave women and families a full explanation when things went wrong. Staff explained what had happened and apologised. They assessed the application of the Duty of Candour against all incidents and maintained and monitored compliance through their maternity dashboard.

The maternity risk team published various newsletters throughout the year. The risk team produced a booklet which included updates related to incidents and any related learning, an update on the maternity risk register, learning identified from patient safety incidents and all term readmissions to the neonatal unit were summarised. The booklet was designed to be a useful learning tool.

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 had clear 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 parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Managers told us they collected data to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women’s care and support. For example, the service offered a breast-pump loan scheme to women who lived areas of highest deprivation and according to specific postcodes. Managers also used this information to inform decisions around service delivery such as community caseloads.

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Engagement

Leaders committed to high levels of constructive engagement with staff and people who used maternity services. Services were developed with the full participation of those who used them. Staff and external partners were seen as equal partners. Innovative approaches were used to gather feedback from service-users, including people in different equality groups, and there was a demonstrated commitment to acting on feedback.

Maternity services worked in partnership with the maternity voices partnership (MVP) to help ensure women's views were represented and maternity services were designed to meet local needs. They worked in partnership to determine how accessible information was and what was needed to optimise care and choice for all women and families.

Maternity services and the MVP worked closely throughout the pandemic to inform women and families about changes, keep them informed and reassured them they were there to support them. They worked together to update the maternity website. The website was comprehensive and easy to use. There was an array of information and videos to ensure women and families were well informed and improve information and support informed consent.

The service collaborated with partner organisations to help improve services for women. They took account of the views of women through the maternity voices partnership (MVP).There was a commitment to work with the MVP and local women to design services to meet their needs. The MVP worked with maternity services to bridge any gaps with women that could be harder to reach.

The service had worked with their local MVP to co-produce leaflets, posters and changes to handheld notes. Leaflets were in an array of languages and available via QR codes. They co-produced surveys and reviewed feedback together. This had led to changes in guidelines and processes.

Maternity services engaged well with women and families and were committed to equality and inclusion for all women. They ran maternity surveys on social media platforms to determine how women wanted to engage and to help shape maternity services to reflect their needs and expectations. Maternity surveys were extending their social media coverage to engage with a wider population including young parents.

The service clearly displayed information about how to raise a concern in women and visitor areas. Information was clearly displayed on information boards in all clinical areas. This included various options. For example, emailing the professional midwifery advocates, the maternity voice partnership, patient advice and liaison service, the debriefing service or the maternity social media pages. The service used social media platforms to connect with women, raise awareness, and act as their advocate.

The director of midwifery (DoM), and deputy DoM ran live video feeds on the maternity social media group. Videos and key messages were shared in various languages such as the importance of monitoring fetal movements and what to do if the pattern changed. Women and families could post questions and received a prompt response. Video feeds started during the COVID-19 pandemic and continued weekly due to interest and positive feedback.

A revised communication strategy was launched in March 2020. This included the introduction of a dedicated social media group for all maternity staff, including the multi-professional teams. There were currently 361 members. The DoM and deputy DoM shared a weekly video update. This included key messages related to recruitment, trust updates and any learning from incidents/feedback. The group also offered staff the opportunity to ask questions at any time. The DoM or deputy DoM responded to questions/comments within 48 hours. There was also direct access to the DoM through messenger.

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A ‘whose shoes’ event took place at an arena in Coventry in June 2022. The event was led by a consultant midwife and lead professional midwifery advocate (PMA). It was a highly participative event, which gave local service-users, the MVP, and maternity staff the chance to talk openly about their personal experiences around key issues in maternity. The event was well attended and provoked a day of discussion, thoughts, and pledges through playing the ‘whose shoes’ game. Staff and service users were able to participate in the game to gather themes and thoughts regarding the topic of wellbeing post COVID-19 pandemic. Themes were drawn from the discussion and formulated the basis for their local maternity action plan.

We saw ‘we are proud’ displays in clinical areas. The displays included a tree with positive comments from staff displayed on tree branches. This was updated by the patient experience midwife. Comments focused on why staff were proud of working for the organisation. The displays added colour, confidence, and a sense of pride across the service.

There were systems in place to engage with staff. There were staff and student information boards in all clinical areas. These included details of how to contact the maternity safety champions, the Freedom to Speak up Guardian and where staff could get support.

Leaders prioritised staff wellbeing. We saw laminated reminders to staff about the importance of taking timely breaks and to escalate if they were struggling to take them. The trust had a scheme known as the Daisy scheme where pregnant women and families could nominate a member of staff for going above and beyond’ their expectations. We heard of recent nominations including a nomination from a mother who had experienced a baby loss and felt her midwife had provided exceptional care.

All staff wore name badges. Theatre staff also had their name and role highlighted on theatre hats to raise awareness amongst women, their support person, and colleagues.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement. Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. Safe innovation was celebrated. There was a strong record of sharing work locally and nationally.

The service had opened a Tommy's National Centre for Miscarriage Research in April 2016. This was the first world-class research centre to be opened dedicated to researching the causes of early miscarriage. The service worked in collaboration with the Tommy's National Early Miscarriage Centre which was a partnership of 3 universities and 4 hospitals. This included University Hospital, Coventry. Women and their partners were given the opportunity to take part in research trials and access cutting-edge treatments and tests. The recommendations from the research had been incorporated into national guidance and raised awareness of the previously unrecognised inequalities around miscarriage that are suffered by black and ethnic minority families.

The advanced clinical practitioner for perinatal mental health achieved an MSc in perinatal mental health including non-medical prescribing. They were involved with two pieces of perinatal mental health research linked with Warwick University. They assessed and managed any diagnostics and referrals. They could enact a deprivation of liberty, if required. Women received prompt treatment, escalation, and safe, sensitive care.

Maternity services commissioned an artist with expertise in creating hospital-based art and info-grams. The designed artwork that created a welcoming atmosphere and aimed to reduce stress for pregnant and labouring women, families, and staff.

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Maternity services were accredited with the Baby Friendly Initiative in 2018. The service was preparing for re-accreditation in 2023. They were committed to ensuring all mothers were supported to make informed decisions about how to feed their baby and respond to their baby.

The local support for frenulotomy (tongue tie division), was removed for women during the COVID-19 pandemic. This meant women could only access this service privately. Maternity services supported two midwives to complete accredited training. The clinic was established in October 2022. They were committed to ensuring all women had equal access to this facility.

Maternity services launched an app for dads-to-be called DADPad. The app provided Dads with guidance on how to support and seek help (when needed), for their partners and themselves, as they adjusted to their new roles. It aimed to help individuals cope with the physical and emotional strains fatherhood could place on individuals and relationships.

Maternity services were supporting an early intervention for new Dads to support their mental health and family support. This was a mixed method project which included 5 phases. Three phases were primary and secondary based research, a systemic review which was in the publication process, a survey for new or expectant fathers, a survey for healthcare professionals working with new or expectant fathers and an interview study with new or expectant fathers.

Maternity services worked with health partners across Coventry and Warwickshire and encouraged parents-to-be to quit smoking. The public health midwife led the 'Love-Your-Bump' campaign to raise awareness, and help pregnant women stop smoking to improve their baby's start to life. Friendly advisers were available to help pregnant women stop smoking.

The public health midwife ran vaccination clinics for pertussis and flu. They completed about 100 vaccinations per week as part of their role. They ran drop-in clinics and walk-arounds to raise awareness about the importance of certain vaccinations during pregnancy or following birth.

Women who had existing medical conditions were seen in multi-disciplinary clinics. The women had access to pre-conception advice and support during pregnancy from specialists who worked in partnership with obstetric staff. For example, there were specialist clinics for women including renal/hypertension, heart disease, epilepsy, diabetes, haematology, complex anaesthetic, history of pre-term labour and multiple births.

We saw and heard examples of staff at all levels provide personalised care. For example, a woman who was booked for an elective caesarean section (c/s) was worried about the environment in theatre. The obstetrician organised for staff to show her around theatres out-of-hours. We saw an anaesthetist place a blood pressure cuff around a mother's calf following her c/s instead of her arm. This was so mum, and baby could enjoy un-interrupted skin-skin contact.

The professional midwifery advocates (PMA) designed an app to support midwives to request immediate and specific support from a PMA. For example, they could request restorative supervision or support writing a statement. The app had been built and costed prior to the COVID-19 pandemic, but the launch was paused due to the impact of the pandemic. The lead PMA was working with research and development and the innovation hub to launch the app to help provide midwives with swift, tailored support.

Maternity

Outstanding practice

The trust was the first university hospital in the UK to be awarded the internationally acclaimed Pathway to Excellence designation.

The service opened a Tommy's National Centre for Miscarriage Research in April 2016 in partnership with 3 universities and 3 other hospitals.

The design of staff training was responsive to their needs and used bespoke programmes combined with cutting-edge technology, and real-life actors. Human factors were weaved into all training to maintain their safety culture.

Maternity services had established one-stop clinics. For example, the INSPIRE clinic for women who had suffered female genital mutilation and the OASIS clinic for women who had an extensive tear following birth.

A neonatal outreach community service (NCOS) was established in September 2022.

Diversity and inclusion were treated with high importance across maternity services.

The advanced clinical practitioner for perinatal mental health who was involved with 2 pieces of perinatal research, and they assessed and managed any diagnostics and referrals.

The vulnerable care team provided continuity of antenatal and postnatal care to women exposed to sex working. This included parent education classes. Antenatal clinics, drops-ins and parent education classes were run from venues known and trusted by sex workers. For example, a street-based outreach service.

Referral pathway and support package for women with alcohol dependency and drug abuse. This included clear inclusion criteria, policies and pathways, a range of support for women, training for maternity staff, specialist support, and advise from the lead midwife. Antenatal appointments and drop-ins were run from venues known and trusted by women. For example, YMCA for homeless people and a centre for support for women with drug and alcohol dependencies.

Midwives worked in partnership with MAMTA to improve child and maternal health outcomes for local black and minority ethnic women to improve outcomes and ensure services were equal and inclusive.

Areas for improvement

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.

SHOULDS

- The service should monitor the interim arrangement to provide a bereavement suite until the formal plan comes to fruition, and ensure the new plan is monitored and implemented as swiftly as possible.

Maternity

- The service should monitor their recent arrangement for additional obstetric cover for triage to ensure any changes are effective in preventing delays in care and treatment.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 CQC inspectors and 2 specialist advisors with expertise in maternity. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.