North Middlesex University Hospital NHS Trust

North Middlesex University Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at North Middlesex University Hospital

Inspected but not rated

We carried out an unannounced focused inspection in the maternity unit of North Middlesex University Hospital on 21 and 28 September 2021. We carried out our inspection in response to concerns about the safety of the maternity services and to see if the improvement plans the trust had put in place were working. The concerns related to the assessing and monitoring of patients and the culture within the service. As this was a focused inspection, our inspection activity focused only on parts of the safe, effective and well led key questions. This means we did not look at all key lines of enquiry in each of the domains.

Focused inspections can result in an updated rating for only key questions that were inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued and requirement notice or taken further action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

We inspected maternity care throughout the maternity unit so we could get to the heart of the patient experience. During the inspection to understand the patient journey and make sure that women and babies were kept safe we visited triage, the antenatal ward, the delivery suite, the midwifery led birth centre, and the maternity assessment unit.

We did not inspect the community midwifery teams because the services were carrying out care within the community and we did not visit services outside of the North Middlesex Hospital on this inspection.

Between July 2020 and July 2021, the maternity services had the following activity:

- Total number of births: 4241
- Total Caesarean (C) section rate: 33%
- Elective C section rates: 14%
- Emergency C section rates: 23%
- Spontaneous unassisted vaginal deliveries: 51.7%
- Proportion of vaginal deliveries in a midwifery led unit: 25.8%
- Instrumental delivery rate: 9.9%

We did not rate this service at this inspection. The previous rating of Good remains. We found:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The training was comprehensive and met the needs of women and staff. Staff had received enhanced CTG training and as a result incidents involving CTG misinterpretation had decreased.
- 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.

Our findings

- Staff completed and updated risk assessments and identified and acted upon women at risk of deterioration. GAP growth assessments had improved, and the service was now above the national average for the detection of small growth babies. The service controlled infection risk well and kept equipment and premises visibly clean.
- The service mostly had enough maternity midwives, nursing and medical 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, and gave bank and agency staff a full induction**.**
- 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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Managers monitored the effectiveness of the service and made sure staff were competent. Training and learning opportunities were available for all staff. Staff worked well together for the benefit of women.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually

However:

- Induction for most staff was comprehensive and tailored to staff's requirements. However, after feedback from junior doctors, the service recognised the junior doctor induction needed more work. There had been some good improvements made, but there was more work to be done.
- The unit co-ordinator role within the service looked at staffing to make sure it was safe with the activity within the department. However, due to the caseload, the co-ordinator role was not always supernumerary, and this meant the service had to find other ways of looking at staffing and organising breaks for staff.
- There was a poster campaign and leaflets available to women to raise awareness of the Covid vaccine. However, we did not find any evidence of conversations or records of advice given to pregnant women regarding the Covid vaccine, in terms of the advantages and risks so women could make an informed decision.
- The service had handover meetings for each shift to discuss continuity of patient care patient. However, the anaesthetist did not attend the morning handover we observed, and this meant not all staff had received up to date information on each patient. This could lead to delays in treatment and diagnosis, inappropriate treatment and omission of care.
- Bed occupancy levels for maternity have been higher than the England average since October 2019. Although there were complex issues that prevented smooth discharge, this meant the services capacity was limited and could pose difficulties in times of more demand.

Maternity

Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory training

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

Nursing, midwifery and medical staff received and kept up to date with their mandatory training. Data provided to us demonstrated an overall compliance rate of over 90% for all topics. Junior medical staff overall compliance was 85%, but this was due to staff movement to other areas and leaving the service. Managers monitored mandatory training and alerted staff when they needed to update their training through the trusts electronic system. We saw evidence of the tracking sheet and future dates when staff were booked on courses, with the latest dates being December 2021. The maternity leads had monthly meetings to discuss training and a monthly report was sent to the director of midwifery and via the safety champion route to the senior leadership team.

The mandatory training was comprehensive and met the needs of women and staff.

In addition to the trust's mandatory training, staff attended Practical Obstetric Multi-Professional Training (PROMPT) style 'skills and drills' training. Maternity services managed to maintain face to face sessions during the pandemic, due to the spacious environment which allowed for social distancing. They adapted smaller classes, but more frequency and other sessions were offered through E-learning which could be completed at home. Again, we saw evidence of dates for those staff who had yet to complete training. The latest dates being December 2021.

Additional clinical 'live skills and drills' training was provided for topics such as pool evacuation, suturing and use of episcissors, cooks balloon and infusion pump/syringe driver usage.

Part of our focused inspection was to see if maternity services had improved the training and monitoring in relation to cardiotography (CTG, which records the fetal heartbeat and the uterine contractions during pregnancy). This was due to a cluster of serious incidents in 2020 in relation to CTG. A themed review found misinterpretation contributed to the incidents.

The trust had taken action by employing a fetal wellbeing specialist midwife with the aim to ensure that relevant staff were assessing fetal wellbeing appropriately, using the entire context of the women's general health, pregnancy, gestation and stage of labour. A new training model had been implemented which focused on individualised fetal physiology interpretation. Masterclasses ran for a duration of 7.5 hours and there were four held per year. In addition to this, staff attended a one-hour update and completed an assessment. All staff had to attend a masterclass session followed by an annual update and competency assessment. The aim of the masterclass was to provide evidence-based training on CTG interpretation based on fetal physiology and real time. Staff were mandated to attend and have their competencies signed off. If staff did not pass, they were provided with one to one fetal monitoring sessions. The overall compliance rate was 96%. CTG teaching was provided on a daily basis.

Maternity

There were weekly fetal monitoring meetings where assessments were reviewed and drop in sessions were provided for staff. There were six fetal monitoring champions who had protected time to practice their role. The fetal monitoring lead created lanyard cards for staff to carry which provided prompts and information on hypoxia at different stages.

Since the revised training and monitoring, there has been a significant reduction in serious incidents in relation to CTG misinterpretation.

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.

Nursing, midwifery and medical staff received training specific for their role on how to recognise and report abuse. Medical and midwifery staff were trained to safeguarding adults' level 3, and could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff were guided by the trusts in date adult safeguarding policy along with female genital mutilation (FGM), and child protection policies.

There was a named safeguarding midwife who had direct links to the associate director of safeguarding. Maternity services shared children's safeguarding specialists from the trust.

Staff had received additional training for safeguarding domestic abuse and there was strong focus on domestic abuse from the adult safeguarding team. Women were asked questions as part of their social wellbeing assessment and this was held on the trusts electronic system. Such cases were escalated to the safeguarding team.

The service was able to collect information from the GP and health visitors at the pre-booking stage, for example, substance abuse cases and this could then be allocated to the appropriate caseload.

There was a proforma staff used to record and escalate safeguarding concerns. Safeguarding concerns were discussed in a multi-disciplinary setting and decisions on planned care were made with involvement of the woman, midwife and obstetrician.

Health visiting services were provided by the same trust and health visitors regularly in-reached to the unit and there were good working relationships between these teams.

The safeguarding team were present within the maternity service and were able to complete acute reviews, for example on substance misuse cases. As a result of working and getting feedback from women, they have recently updated their consent to toxicology pathway.

The service had a named FGM midwife where cases could be escalated to and they also worked clinically within maternity triage. In addition, there was a specialist FGM consultant. They ran clinics for women including de-infibulation. De-infibulation is surgical treatment for female genital mutilation.

Maternity

There were good relationships with external safeguarding bodies. The trust had representation at local authorities of both local boroughs, and both boroughs accepted one safeguarding referral form from the hospital for consistency and ease of use for staff.

The service held bi-monthly vulnerable women's meetings where safeguarding referrals and themes identified were discussed.

There was an out of hours manager on call for safeguarding referrals. They kept staff updated on cases on the ward and cases being admitted.

If a woman did not attend appointments on a frequent basis, they were referred to social services as indicated in the trusts Did Not Attend policy.

At the time of our inspection the updated child abduction policy was being ratified and the trust sent the new updated policy after our inspection. We saw evidence staff had attended baby abduction drills.

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.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw evidence that maternity services undertook cleaning audits and actions taken to address any concerns. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff practice good hand hygiene methods, and hand sanitizer was available for staff, patients and partners. At the entrance of the maternity unit, visitors were given a clean face mask and asked by staff to use the hand sanitizer before going to other areas. Hand hygiene audits from the last six months showed a consistent compliance of 100%.

Women and partners were asked to complete a lateral flow test prior to attending any appointments. Women had a PCR test on admission and women were also tested for Covid 19 during pre-elective checks.

We reviewed a selection of IPC audits which showed a consistent compliance of 95% with regards to cleaning. Environmental audits were conducted, and they covered a variety of areas, such as the patient's environment, patients' toilets and showers, clean utility room and sluice room. Audits showed checks on these areas were compliant and actions taken when not. For example, in one bay the gel dispensers were empty and domestic staff were asked to refill.

Cleaning guidance displayed above the birthing pools was not consistent. The dosage of the cleaning tablets recommended was different to the dosage of cleaning tablets provided. We fed this back to the trust and on our return on 28 September we saw information had been updated to reflect the changes. Staff demonstrated how they cleaned the birthing pools daily and we saw the daily logs of cleaning records were up to date and complete.

PPE observational audits we reviewed showed a consistent compliance of 90% and above for each area within maternity services. All staff groups were observed for practices such as staff wearing gloves and aprons when within two metres of patients, staff wearing surgical masks and appropriate PPE worn depending on procedure.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Maternity

Clinical maternity dashboards displayed on each ward showed there had been no cases of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) or clostridium difficile (C-Diff) infections within the past month.

Maternity services had a lower rate of unplanned maternal readmissions within 42 days than the national average.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fairly new, and facilities were modern and spacious.

The service had suitable facilities to meet the needs of women's families. There was a delivery suite which consisted of 15 birth rooms and a blue bay with four beds for induction. The delivery suite had one birthing pool. The birthing centre had eight rooms in total, four with birthing pools. There were double beds so the partner could share the experience and birthing aids, birthing chair ropes and physio balls. Mood lighting was available in all the rooms.

The antenatal clinic was spacious with enough room to accommodate social distancing. The triage clinic had four clinical rooms and four induction of labour beds. These beds were based downstairs to the labour ward and women had to be moved upstairs during the evening to accommodate safe staffing. Although the trust recognised this was not an ideal experience for the women, they had not received any negative feedback and the trust were due to recruit a midwife for the night shift.

There was a bereavement suite placed at the end of the labour unit. Although not ideally placed there was a separate staircase for entry. However, after a security risk assessment the staircase was not in use. The suite was soundproofed.

Two operating theatres were located on the delivery suite and near to the neonatal unit. This enabled the unit to provide emergency care without delay and these were available 24 hours a day seven days a week. The unit had access the trusts main theatres if required.

The service had enough suitable equipment to help them to safely care for women and babies. The maternity day unit had new easy wipe CTG machines. Equipment we checked, such as blood pressure monitors, resucitaires and defibrillators had up to date safety checks completed on them.

Staff carried out daily safety checks of specialist equipment. We saw daily checklists had been completed on the three resuscitation trolleys and two resusitaires we reviewed. Routine audit checks were completed on the checks to ensure were completing them correctly.

Stock was reviewed on a weekly basis and non-reusable items we checked were in date.

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

Maternity

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The Maternity Early Obstetric Warning Scores (MEOWS) system was in place and records we reviewed showed staff used the tool appropriately. Audits for the past six months demonstrated a compliance rate of over 95%. The audits included appropriate escalation. Surviving sepsis criteria was triggered for a score of six or more with immediate escalation to the senior obstetrician. Women at high risk were moved onto the high dependency charting.

In triage, the Birmingham Symptom Specific Triage System (BPSOT) had recently been introduced. The system identified a woman's presenting condition, key clinical symptoms and vital signs. The information is then red, green amber (RAG) rated so appropriate escalation was made. As this had recently been introduced audits had yet to be completed. However, feedback from staff was positive.

For the 13 records we reviewed staff had completed risk assessments for every woman's antenatal appointment and women with more complex pregnancies were offered specialist antenatal clinics. For example, women with diabetes had access to clinics run by two diabetic consultants who provided blood sugar teaching. There were four diabetic obstetricians and joint obstetric and medical clinics were run.

Other antenatal clinics for complicated pregnancies included cardiac, haematology, fetal medicine, sickle cell, substance misuse, high BMI, infectious diseases and recurrent miscarriage clinics. A specialist consultant was attached to each clinic. There was a consortium approach to smoking cessation and there was a once a day clinic held at the service.

We saw evidence of a referral for a patient who had tested positive for an illegal drug. A referral form had been completed for the substance misuse clinic, and records showed discussions and assessments had been made with the woman on medical and risk factors.

There had been three serious incidents in 2020 with regards to GAP Grow charts not correctly being completed. A GAP Grow quality improvement project resulted in more enhanced training for staff and staff were able to demonstrate during the inspection how they plotted fetal measures and what measures they would take if additional support was required. For example, women whose babies were showing as 10th or below centiles on growth charts were booked to see a consultant with twice weekly CTG, a doppler fetal scan and twice weekly grow scans. Since October 2020 to present, the trust have received recognition from the Perinatal Institute for being above the national GAP average for detecting SGA <10th centile, since quarter 3 2020/2021, and were in the top 3 trusts for it's detection rates during quarter 4.

There was a new fetal monitoring guideline which specified how and when to carry out 'fresh eyes' process with regards to CTG and a fresh ears buddy system. Fresh eyes are recommended by national guidance to ensure CTGs have been correctly interpreted and escalated if appropriate. Audits completed by the fetal monitoring lead showed over 95% of one hour fresh eyes checks were being completed. We saw evidence in records of CTG escalation whereby a co-ordinator visited within three minutes of the escalation. Staff had annual competency checks for GAP growth charts. The training was both face to face and E-learning.

There was a GAP compliance plan, and this was monitored at monthly governance meetings. Ongoing actions included advertising for more GAP champions, and this was in progress at the time of our inspection. Since the improvement project GAP Grow incidents related to the chart not generated/incorrectly generated during antenatal period had dropped by more than half from August 2020 to May 2021.

Maternity

Umbilical artery doppler checks at 20 weeks is one of the primary surveillance tools for detecting a SGA fetus. The trust had formally implemented this procedure during our inspection (27 September 2021) and as of yet had not conducted audits to monitor progress. It was too early to tell if this was firmly embedded into practice. A standard operating procedure was in place and we were told this would be monitored on a quarterly basis. This was an action on the GAP compliance plan and was being monitored through the monthly governance meetings.

Women were offered Vitamin D appropriately. Vitamin D helps the body absorb calcium and phosphate making it vital for healthy bones teeth and muscles. This was particularly relevant for Black, Asian and Ethnic Minority (BAME) babies as deficiency in Vitamin D was higher in BAME babies. Records we reviewed showed conversations had been held with women and Vitamin D offered appropriately. The standard operating procedure for 'High Risk Antenatal Clinic pathway modified for Covid 19' included information that, all women, especially BAME women, should be advised to take Vitamin D supplementation throughout pregnancy.

Carbon monoxide monitoring was monitored at the early stage of women's pregnancy and again at 36 weeks. This service was suspended at the start of the pandemic but re-introduced in May 2021. Audits showed monitoring was more robust at the booking stage, but not so much at 36 weeks, and the message had been reinforced to staff. Further monitoring was in place to see if improvements had been made in this area.

We saw evidence of the trusts 'keeping mothers and babies together pathway of care' for high risk babies. The pathway allowed the medical and midwifery teams to easily identify more vulnerable babies and support families in looking after them. Babies wore an orange hat for the first 12 hours of their life. This helped the team identify which babies needed extra care and timely observations.

There was a 12 hours of care pathway, where additional assessments, prompts and flow charts were completed for babies with respiratory distress.

High risk women who were red rag rated in triage were seen within 30 minutes by a midwife and within an hour by medical staff. The service audited the waiting times and results showed over 96% of women between January 2021 and August 2021 were seen within 30 minutes by a midwife and within an hour by medical staff. 18.2% of patients on a less risk pathway waited longer than an hour to see medical staff. The reasons for the longer waiting time were not given in the audit.

Venous thromboembolism (VTE) assessments were recorded at booking, following birth and at every admission from the records we reviewed during our inspection.

The service monitored the modified WHO maternity theatre checklist and audits showed full compliance. Swab count audits were conducted to ensure compliance and we saw audit results had shown an improvement since 2021. Preoperative safety checklist were completed and traceability records, and blood loss records as well as swab counts were monitored for those women who underwent surgery.

Staff shared key information to keep women safe when handing over their care to others. Staff handovers followed a situation, background, assessment, recommendation (SBAR) format, which referred to women's physical, psychological and mental wellbeing. On the whole the handovers we attended followed the SBAR format, however the anaesthetist was not present during the medical/consultant handover. However, the standard operating procedure for consultant led labour ward rounds and handover, stated for an anaesthetist to present if available.

Maternity

There had been no reported incidents of pressure ulcers from January 2021 to date and no reported incidents of falls since February 2021.

Midwifery staffing

The service mostly 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, and gave bank and agency staff a full induction.

The service mostly had enough nursing and midwifery staff to keep women and babies safe. There was an effective system of midwifery workforce planning, using a recognised workforce planning assessment. This was based upon an understanding of the total midwifery time required to care for a woman and on a minimum standard of providing one-to-one midwifery care throughout established labour. This methodology was consistent with recommendations in the National Institute for Health Care and Excellence (NICE) safe staffing guidelines for midwives in maternity settings and have been endorsed by the Royal College of Midwives and Royal College of Gynaecologists.

Managers accurately calculated and reviewed the number and grade of midwives, nurses and maternity support workers needed for each shift in accordance with national guidance. However, the number of midwives and maternity support workers did not always match the planned numbers and each shift usually had one, sometimes two midwives short. Managing staff levels was challenging due to the different levels of acuity in the women they saw. Added to that, if a staff member was sick, this presented further pressure. The summer months had been challenging due to staff leave.

The service had low vacancy rates of 4% and this had reduced from 19% in 2018. There was a total of 32 whole time equivalent (WTE) vacancies within maternity services. Band 6 vacancies within the labour ward was 11 WTE and 7 WTE in the maternity ward. Sixteen midwives were due to qualify this year and were due to take permanent posts within the service. The midwife to birth ratio was 1:28, however this was due to improve to 1:25 when the newly qualified midwives started at the end of this year.

On average, the service used approximately 30 whole time equivalent (WTE) bank staff on a weekly basis, predominately in the labour ward. There was a business case to increase bank staff that was currently in progress. Agency usage was low and approximately 3 WTE agency staff were used on a weekly basis. If agency staff were used this had to be escalated 48 hours in advance. Managers made sure all bank and agency staff had a full induction and understood the service

Staff told us although staffing levels looked favourable in comparison to the national picture, the impact of the patient acuity, alongside long-term staff sickness and maternity leave, meant that they were experiencing ‘burn out’.

A unit co-ordinator looked at staffing to make sure it was safe with the activity within the department. They organised break reliefs, and mobilised staff from other areas. They had a daily review with the site team at, 8am, lunchtime and 6pm. However, due to the caseload, the co-ordinator role was not always supernumerary. Specialist midwives helped with making sure staff had a break. There had been 10 reported incidents from October 2020 to September 2021 where a staff member did not have a break.

There was a lack of neonatal nurses, qualified in specialty, as part of the transitional care team on the maternity ward. This was a risk on the risk register due to the requirements of BAPM (2019). There was however a team of dedicated nursery nurses as part of the maternity ward establishment who cared for babies on transitional care pathways, with a midwife and supported by a neonatal nurse. There was a service assured sector wide QI project, and there have been no reported incidents from the shortages.

Staff were able to report the level of harm when reporting staff shortages. We were told by staff; more additional filters were being added so staff could provide more in-depth reasons, and this would allow the trust to identify more in-depth themes and trends. We were told this was a relatively new system and had yet to be audited.

Some staff said the new system for requesting bank and agency staff was problematic. Staff said the control had been taken away locally and was more central, yet this posed difficulty as approval took longer, and therefore, shifts were taking longer to fill. However, the trust had made significant progress in reducing the reliance on bank and agency staff and they told us agency shifts where needed were escalated with a 48-hour lead time, or short notice for last minute sickness and absence. The approval process was completed in hours by the divisional director of midwifery, the associate director of midwifery or by the out of hours midwifery manager or trust silver on-call manager.

There was an escalation policy in place, and they tried not to use community midwives. However, there had been two occasions when on call community midwives were asked to work in the labour ward. Although the service was able to ask on call community midwives, it is only requested as a last resort. It was recognised that community midwives felt more comfortable working in the birthing suite as they had to refamiliarise themselves with working in the labour ward. After discussions between staff it was agreed that on call community midwives, if asked to cover a shift would work in the birthing suite.

There was no dedicated night shift midwife to cover the induction bay which was based downstairs to the labour ward. This meant women were transferred for the induction part of their labour and although there had been no complaints from patients, the service recognised this was not the best experience for women. The service was in the process of recruiting for this post with Ockenden funding they had.

Maternity services produced a twice-yearly midwifery staffing review which was presented to the maternity board and up through quality committee and to the trust board. This included level of harm and any 'red flag' incidents.

Medical staffing

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

The service had mostly enough medical staff to keep women and babies safe. Obstetric and Gynaecology staffing establishment was 44 WTE. As of 26 September 2021, the established vacancy was six WTE medical staff. There was a 6% vacancy rate for junior medical staffing and 0.1% senior staffing vacancy rate.

The trust provided 98 hours per week of cover by consultant obstetricians between 8am to 10pm Monday to Sunday. Consultants conducted two ward rounds and two board rounds and one MDT safety huddle within a 24 hour period. During the hours of consultant presence there was at least two full ward rounds and two full board rounds. However, it was accepted that in certain periods of intense level of activity, for example, emergency caesareans it may not be possible to complete the rounds at the allotted times. There was a gynae hot week registrar consultant cover for the whole of gynaecology department. The service always had a consultant on call during evenings and weekends.

The clinical director had a weekly review of cases, to make sure there was suitable cover for patients. Managers could access locums when they needed additional staff. Locums used, were usually previous staff who had worked at the trust. There was recognition that it was difficult to recruit junior doctors' and that recruitment was an ongoing rolling process. The service used the emergency pathway if short of staff, however the service had not had to cancel any clinics due to shortage of consultants.

Maternity

There was a consultant anaesthetists available 24 hours seven days a week dedicated to the maternity service

Records

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

We reviewed 13 patient records, reviewing women's whole pathway of care for six of the records. Four records were reviewed at the labour ward, two in the delivery suite and one within the triage unit. Records were both electronic and paper based. A new digital midwife had been recruited to help the system become paper lite.

Most women's notes were comprehensive, and all staff could access them easily. However, for three patient records on the labour ward there was no timely consultant review documented at the appropriate stages for women's assessments of care. We fed this back to the trust and they were able to provide evidence that these patients had been assessed and monitored by the consultant at the appropriate time. However, they had not recorded their assessments in the patient's paper records in a timely manner. All other records we reviewed showed good consultant reviews at the appropriate stages.

Records recorded the woman's choice, risk assessments, mental health assessments and referrals to specialist services. For example, women with diabetes had a different colour coded set of notes within their record. One record we reviewed indicated language barriers and the support systems required for this. A Greek language leaflet had been given to the patient and the antenatal risk factors identified screening for down syndrome, CTG proforma had been completed and the midwife notes were clear and comprehensive.

The ethnicity and risk factors, for example postcode, comorbidities to identify those most at risk of poor outcomes were recorded.

There was a poster campaign and leaflets available to women to raise awareness of the Covid vaccine. However, we did not find any evidence of conversations or records of advice given to pregnant women regarding the Covid vaccine, in terms of the advantages and risks so women could make an informed decision.

Records we reviewed showed the application of fresh eyes was embedded into practice. There was a standardised CTG sticker staff could use and complete the relevant boxes in the sticker.

When women transferred to a new team, there were no delays in staff accessing their records and records within the service were stored securely.

Following birth parents were given a personal child health record book.

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 patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. There was a good reporting culture within the whole of maternity services and an open and transparent approach to the sharing and learning from incidents. Staff raised concerns and reported incidents and near misses in line with trust policy.

Maternity

Managers investigated incidents thoroughly. There was a triumvirate approach to the investigations of serious incidents. The incident report was sent to the general manager, associate director of midwifery and clinical lead within maternity services. At a higher level the incident was shared with the divisional clinical director, divisional director of midwifery, nursing, and divisional director of operations.

Once a week, potential serious incidents and serious incidents were shared at the trust's governance review panel. The meeting was chaired by the chief nurse and membership included the divisional directors of nursing / midwifery, AHPs and quality, the deputy medical director and representation from divisional and central governance teams. A weekly governance report detailing serious incidents was produced for the executive team and discussed at the executive team meeting. This meant there was oversight from the board and throughout maternity services.

Serious incidents were seen by the risk team at a multidisciplinary meeting for quality checks before being sent for sign off by divisional risk manager and divisional director of midwifery. External partners from commissioning groups attended a multidisciplinary meeting to pose questions and joint recommendations were made. Actions from incidents were logged on the electronic reporting system and a person assigned to actions was alerted with a date to finalise actions. The trust often got external independent experts to assist with independent reviews and often invited staff to panel. We saw evidence that women and their families were involved in these investigations.

A central governance team amalgamated all incidents reported onto a spreadsheet once a day and this was sent to maternity leads as well as the risk team. This meant identification of themes and trends could be made in real time. There was a trust rapid review document for serious incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and looked at improvements to patient care. There was a governance wallboard for staff which displayed a list of serious incidents and Healthcare Investigation Safety Branch (HSIB) cases with updates and lessons learnt. Information of thematic reviews was also displayed for staff. For example, we saw information on a case review feedback on shoulder dystocia, good practice and learning points.

We reviewed the HSIB report of May 2021 which gave an overview of national and regional data and specific data related to the trust. Recommendations were under the headings risk assessment, guidance, clinical oversight and escalation. HSIB referred to the good working relationship they had with maternity services.

Learning was widespread and comprehensive. There was formal feedback on a personal level with a professional midwifery advocate for education support of required and doctors had a colleague to tutor. Real cases were used as examples through education. For example, the fetal monitoring midwife was able to use real cases for PROMPT scenario-based training. There was quarterly learning event on Teams where non- executive directors and safety champion were invited and where key examples of cases where learning had been gained could be used by staff for continued professional development.

Learning was also shared through round table events, maternity governance newsletter, wall of knowledge, clinical governance notice boards and there was a maternity learning folder on the trusts electronic system.

Managers debriefed and supported staff after any serious incident. Serious Incident aftercare was a relatively new service to support staff and teams involved in serious incidents.

Maternity

There was a standard operating procedure for reflective learning in practice for fetal monitoring misinterpretation incidents, the purpose to provide a supportive consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.

All investigations had human factors included in their investigations to get a context of the incident and for a holistic approach. There were four accredited human factors trained staff which included the maternity risk team.

There was a perinatal review for all stillbirths and whole investigating actions were completed in 100% of all cases.

For neonatal deaths, 48-hour reviews were conducted and there was a prescriptive structured document which covered obstetric and neonatal management.

There had been no reported maternal deaths since 2016.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. There were 18 guidelines awaiting upload to the electronic system and nine guidelines were in the process of being updated and ratified. The trust was in the process of recruiting an administrative staff member to assist with the uploading of guidelines.

Paper guidelines were distributed throughout the service. For those guidelines being updated, changes were cascaded to matrons for distribution and monthly newsletters provided information on updated guidance.

There was a guideline midwife who attended huddles to provide updates to staff. The senior team within maternity services met with the guidelines midwife on a weekly basis. The guidelines midwife supported by an obstetrician did skills sessions once a month after guidance had been shared to see if it was understood and embedded into the service. Plans were in place to have monthly quizzes with staff on updated guidance.

Updates about guidelines were shared with staff via team huddles and meetings and via the women's health newsletter and posters in all clinical areas and email. Staff were encouraged to find information about guidelines in the maternity education room wall and updates were included on their mobile maternity risk board.

We reviewed a selection of policies such as, effective fetal monitoring, reduced fetall monitoring, hypertension in pregnancy, obstetric cholestatic and shoulder dystocia. The policies were in date and followed professional guidance such as The Royal College of Gynaecology. The smoking in pregnancy Version 2 followed guidance for element 1 of the Saving Babies Lives care bundle.

Maternity

The trust had updated policies and standard operating procedures (SOP) during the pandemic to support safe care for women. For example, there was a Coronavirus (Covid 19) Infection in Pregnancy Policy and these followed guidelines defined by Public Health England. Other policies included Covid 19 Antenatal and Postnatal Care During the Evolving Pandemic.

There was oversight of guidelines and the content. For example, we saw for guidelines on the management of gestational diabetes mellitus in pregnancy, there had been discussion about the information contained in the guidelines. At the time of our inspection the guidance had been approved and updated.

Women with risk factors for gestational diabetes were identified and offered glucose testing. Their care was transferred to the obstetric consultant managing diabetes in pregnancy.

Women presenting with mental health conditions were referred to the perinatal mental health team.

We saw evidence of a full audit schedule that was embedded into the service.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes

The service participated in relevant national clinical audits. Outcomes for women were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women's outcomes.

The service had taken part in the National Maternity and Perinatal (NMPA) Audit 2019. The NMPA clinical audit showed the trust's emergency caesarean birth rate was 19.9%. The service performed well for obstetric haemorrhage of 1500ml and were in the expected range for other measures.

The most recent report (2019) for readmission rates showed the service had a readmission rate of 3% against a national average of 3.6%.

The National Neonatal Annual Report 2020 on reported data for 2019 showed the trust was meeting or nearly meeting national rates. For example, babies born at less than 32 weeks gestation, who had an appropriate temperature on admission to the neonatal unit was 69% against a national rate of 70%.

The service had a quality improvement tracker for Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACCE). We saw most actions had been completed, for example, for obstetric haemorrhage, skills and drills training during PROMPT sessions was taking place.

The service conducted a snapshot audit in June 2021 regarding induction of labour. This related to the number of women who were induced through triage during the month of June 2021. The audit identified the parity which showed 41% of women induced were women who were pregnant for the first time. The ethnicity of women was recorded, and this showed the highest proportion of women induced were of Eastern European ethnicity. The mode of delivery was audited along with whether they had to have a caesarean. Recommendations from the audit indicated a deep dive was needed and to monitor women's feedback regarding the induction of labour environment.

Maternity

Disparity exists in maternal and infant birth outcomes of Black and Minority Ethnic (BAME) women giving birth. The service had initiatives in place to monitor outcomes for BAME women. The service had a review and analysis of Covid 19 cases and were able to identify the higher proportion of women affected by their ethnicity.

There was a BAME benchmark and action plan. Requirement and work involved including collaborating with external partners. We saw evidence of actions taken, such as minimising the risk of Vitamin D insufficiency. Vitamin D had been dispended in the antenatal clinic since December 2020 and a Vitamin D leaflet was updated to have specific information regarding Covid 19 and BAME women, and this was in circulation.

The Magnolia perinatal team were able to measure the outcomes and the effectiveness of their service.

There was a maternity dashboard based on Royal College of Gynaecology (RCOG) guidance.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. However, the service was currently reviewing the junior doctor induction as they recognised improvements were required in this area.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us the appraisal system had improved and was more meaningful. The service used a scope for growth approach, which was focused on talent conversations, a conversation focused on their potential and career not just their performance. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff had individual development plans in line with the trust's values. The trust's appraisal window was open at the time of inspection and appraisals were in progress. Latest information showed 89% of midwives had received an appraisal and 60% of obstetric medical staff had their appraisal completed with a further 10 underway and in process.

There was an education team and preceptorship programme which lasted 18 to 24 months which covered the whole of the service. Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Feedback from junior doctors was extremely positive on the support and guidance they received from consultants.

Competency assessments were completed for fetal monitoring training. We saw evidence of 2021 competency assessments whereby no staff had not achieved the required standard. Personalised reflective learning was in place for any fetal monitoring misinterpretation incidents.

There was a comprehensive training programme in place. There were several leadership programmes available for staff including outstanding leaders programme, Mary Seacole Leadership programme and Florence Nightingale Emerging leader programme and the Windrush Leadership Programme. This was a bespoke leadership programme for band 5, 6 and 7 nurses and midwives from a BAME background. We saw evidence of midwives, consultants and other staff members including service managers had attended these different programmes.

Medical staff had additional training sessions included perinatal mental health, fibroids, pelvic pain and cervical screening.

Maternity

In line with national policy, the trust had implemented the Advocating and Educating for Quality Improvement (A-EQUIP) system. This system supported midwives through the process of restorative clinical supervision and personal action plans for quality improvements.

Maternity services had five professional midwifery advocates (PMA). The aim of the PMA was to support midwives in their clinical practice and advocate for women with the objective of their role providing restorative clinical supervision; advocacy and support, quality improvement activities, education and leadership for midwives. However, some staff we spoke with were not clear of the difference between a PMA and manager.

We received positive feedback from student midwives on the support and development they received during their placement. The service won placement of the year award 2019/2020 for student midwives from the university students attended.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service held twice daily MDT handovers at shift changes, to discuss patients and followed a SBAR process when doing so. Handover boards were updated with key information on patients, so concerns and risks could be managed and escalated. The risk midwives kept updated with handover boards so risk could be monitored.

Daily cross site huddles were conducted to discuss safe staffing, bed availability, admissions and discharges.

There was a specialist case holding perinatal mental health midwife and consultant team 'Magnolia team' who specifically dealt with women with perinatal mental health conditions. The team held a clinic with involvement from psychologists and psychiatrists to discuss cases and provide holistic care for patients, such as mindfulness sessions and art therapy. The team provided enhanced antenatal care during all lockdowns when face to face appointments for women had stopped with other external organisations. The team visited women in their homes and therefore saw women at the crucial time when they needed support. The service had been shortlisted for a Royal College of Midwives award. Since the inspection we have learnt the trust had won this award.

The service was currently piloting 'Maple' service, a service for people who experienced fear, trauma or loss arising from pregnancy or birth related issues. The woman and this could include their partner had a psychologist throughout their pathway of care and could use their services for up to a year after they gave birth.

Midwives told us they had good access to consultants and felt comfortable to challenge decisions if required.

In 2020 the whole of maternity services apart from the labour unit moved to a football stadium to provide safe maternity care during the height of the pandemic. This was accomplished within a matter of weeks through good collaborative working of the whole of maternity services.

Is the service well-led?

Inspected but not rated

Maternity

Leadership

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

The maternity board senior leadership team were a triumvirate led by a divisional director of operations, divisional director of midwifery, nursing, AHP and quality and a divisional clinical director. Below this level another triumvirate of management included the associate director of midwifery, clinical director for women's health and general manager for women and children.

The maternity board had developed a maternity safety improvement plan, which included recommendations from the Ockenden report and external review. The service was on track with the majority of recommendations. For example, a recommendation from the Ockenden report recommended the recruitment of a digital midwife and this was in place at the time of our inspection.

The director of midwifery and associate director of midwifery were both very visible within each department and staff told us they were both approachable and could discuss any issues and concerns.

Staff said they frequently saw the Chief Nurse who visited the service and they too were approachable. Staff were impressed with the new Chief Executive who had visited the unit and had attended several meetings. One staff commented that the CEO had remembered their name when they next met them. Staff said they did not often see other members of the board, but footfall had been reduced to a minimum during the pandemic.

The senior team had a good understanding of the day to day pressures and risks. For example, the director of midwifery knew the top concern amongst staff was about staffing levels and that staff were currently feeling tired. We could corroborate this with staff we spoke with during the inspection.

Community staff felt they were part of the acute trust. They had a hub within the maternity services so were often present at the main site.

The Chief Nurse was the board executive safety champion and had direct access to the senior leadership team.

Culture

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

In 2020 we received information of concern from staff regarding claims of bullying, harassment and cronyism within the maternity department. We spoke with over 25 staff of all levels during the inspection and was told, although there was a difficult period in 2020 due to the pandemic and movement within the department, the culture had much improved over the past year and there was a more open and transparent environment. Staff felt confident to approach the senior team within the department to raise concerns.

There were still pockets of concern, which the senior management were aware of and the staff we spoke with felt confident the concerns would be dealt with fairly. Senior management recognised improving the culture was ongoing and a work in progress.

Maternity

Staff said the divisional director of midwifery, nursing, AHPs and qualitythe new associate director of midwifery were approachable and there had been a strong focus on providing development and learning opportunities which staff said had improved within the last year.

Although staff said the culture issues from 2020 had improved, they currently felt tired and 'burnt out' due to the high acuity caseload within the unit. The unit served a diverse population and high risk patients, so although the staffing figures looked relatively good, staff felt that the reality was different. The demands of dealing with more high risk patients meant more one to one nursing care and this had an impact on the staffs working day. The senior team recognised more open communication and dialogue was needed with staff to address their concerns and were planning to have a meeting to discuss the issues.

The service provided wellbeing initiatives such as a wellbeing room and wellbeing team Schwartz rounds. However, staff said they did not fully access the services as they were too busy.

We spoke with the HR director and they were able to explain the recruitment process and how inclusion champions were included in the recruitment process of Band 8C and above. They were able to halt the process if they felt the process was not fair.

The trust were currently working with an external organisation to work on culture within the department, with a purpose of providing a support service in reviewing relationships and people management processes as well as identifying appropriate interventions.

The freedom to speak up guardian (FTSU) set up twice monthly workshops and these had started in July 2021. The FTSU had conducted walk arounds within the department. Monthly meetings are held with the FTSU and senior team within maternity services. The FTSU had met with the antenatal team every three weeks. There was good feedback from the sessions and by the third meeting staff fedback the meetings could be held monthly. Themes and celebrations are discussed in the meetings.

The service were currently piloting on behalf of NHS England 'scope for growth' which is a person centred talent management process, developing champions which the trust were in the process of starting in October 2021. The process encompassed 'what I want as a midwife' and was not manager led but employee led.

Pulse staff survey results conducted in August 2021 showed the service scored higher for engagement than the trust target. They scored better for fair opportunity for progression. However, the senior team recognised there was ongoing work to be done in specific areas of the unit.

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.

There was a maternity quality improvement plan to triangulate recommendations and track quality improvement programmes and actions through the maternity board. The board had oversight and consistently reviewed the Savings Babies Lives bundle, Ockenden report, Perinatal mortality report, HSIB and maternity services data through their clinical dashboard. They tracked performance recommendations from external organisations.

Maternity

There were divisional quality governance meetings held on a monthly basis, with a structured agenda under the headings, safe, effective, caring, responsive and well led. There were actions logs from the meeting with a named lead for each action. We reviewed a selection of meeting minutes and saw risks, complaints, local policies, patient experience, clinical audit, incidents and training were discussed.

Women's services also held their own governance meeting which discussed more specific issues related to their area. For example, August 2021 meeting minutes showed discussion on the Birmingham Symptom Specific Obstetric Triage system being introduced into the service.

There were structured forum meetings held at a local level for each department such as labour ward, matron meetings, community midwives, and postnatal. We reviewed a selection of meeting minutes and found issues relevant to their area were discussed for example risks.

Recommendations and actions from the Ockenden review had been completed for most recommendations. For two aspects of a recommendation the trust were awaiting updated national guidance which was outside of their remit. Another recommendation in relation to midwifery/leadership, to develop a business case for consultant midwife for public heath was still ongoing due to staffing re-structure.

As a trust they were achieving the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme and will continue to receive a refund which will be reinvested into the service.

There was a proposed Better Birth domino service being introduced. The Better Births national policy sets a specific expectation that each woman will have a midwife she knows at birth. The domino service being implemented was a midwife led maternity service available to women with normal low risk pregnancies as part of Better Births continuity of care model.

Saving Babies Lives Care Bundle V2 (SBLV2) was a care bundle for reducing perinatal mortality. The service audited the SBLV2 and results from May 2021 audit showed the service was compliant with the majority of the five elements. On two areas that required improvement the service had put action plans in place. For example, for percentage of women booked for antenatal care who had received a leaflet/information by 28 weeks of pregnancy, the action included staff having to document that the leaflet had been issued at the booking appointment on the electronic record system.

There was good governance and oversight in relation to investigation and management of serious incidents and the trust were open and engaged to external independent reviews to find ways of improving.

The service displayed quality information in public areas of the department, that displayed information on incidents, complaints mandatory training rates and infection prevention and control.

There was a Local Maternity System (LMS) which is a partnership of organisations, women and their families working together to deliver improvements in local maternity services. The risk and governance lead attended monthly meetings where themes were identified, and shared outcomes were discussed. These were then brought back at board level and discussed.

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

There was a maternity dashboard and findings were discussed at board and divisional meetings. Information was disseminated to staff through their local risk and team meetings.

There was maternity risk register and staff knew the top risks within the service. There were bi-monthly action and review meetings for continuous oversight and each risk was rated in accordance to severity. The risk of non-detection of growth restricted babies (SGA) due to poor compliance with GAP GROW practice was still on this risk register even though there had been improvements in this area. The risk rating had been reduced. Due to ongoing monitoring to ensure good practice had been embedded into the service, this was still placed as a risk.

There were two risk midwives and maternity risk manager based within the service, who managed risks and incidents and provided a supportive role for staff. For example, for third degree perineal tears they ensured all the information was included in the electronic reporting system and made sure of investigation. They attended safety huddles with staff and looked at staff handovers to make sure risk had been monitored.

Maternity risk champions were in all clinical areas throughout maternity services. There was a maternity safety champion update provided on a monthly basis which gave a maternity risk update. For example, we reviewed the August 2021 briefing. There was an overview of incidents by location over time and actions taken. There were updates on Healthcare Safety Investigation Brance (HSIB) investigations. There were 15 completed reports, three of which had no safety recommendations, two were in draft and three reports in progress. Bi-weekly update meetings were held with the risk team and HSIB maternity investigator. The service had a good working relationship with the HSIB and invited them to investigate incidents even if they did not meet their criteria for learning and development.

As of January 2021, the service had reported 14 cases to MBRRACE. All cases had been reviewed with the correct timeframe at the review panel.

Interpreting services was identified as a risk on the risk register due to gaps in the provision by the external interpreting service. Access and assessment to language support for the diverse population they served was essential in providing safe maternity care. There were over 100 different languages spoken by people who used maternity services. Staff told us the external interpreting service was not always reliable and the trust were in the process of reviewing the agreement. The trust had employed three Turkish translators (as this was the most common non-English speaking language) and this worked well. Many staff within maternity services spoke different languages and staff could be utilised to communicate with people when required. However, this was an area which required further improvement and was an ongoing project. They were currently undergoing a 12 month look back at incidents where translation was a factor and will conduct a roundtable to understand if it was about accessibility or staff understanding. Visual aids and leaflets were provided in the top languages spoken and translation services were available on the trust website.

Bed occupancy levels for maternity have been higher than the England average since October 2019. The service had a lot of complex discharge issues relating to issues such as housing problems, substance misuse, protection plans and safeguarding which contributed to the higher than expected levels. The service were working on various projects to try and find ways of reducing the bed occupancy levels and these were still ongoing at the time of our inspection.

Engagement

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

Maternity

The service engaged with the Maternity Voices Partnership (MVP). Relationships between the MVP and some members of staff within maternity services had deteriorated and mediation was in place to develop a more improved relationship. There had been some good collaborative work, such as the development of leaflets providing information on Vitamin D, so there was recognition of the value and importance of the MVP role.

The service had developed a mum and baby app, a resource designed to give people choice, information and personalisation to improve women's experiences of maternity care and to make sure that the information they received was NHS clinically approved and consistent. This was a collaborate project which involved a number of external stakeholders.

People were able to provide feedback through an interactive system for the friends and family test and through the trusts website. There was a patient advice and liaison service (PALS) which offered impartial advice and assistance to people.

There were various engagement initiatives the service was holding in recognition of staff and learning events. For example, 'International day of the midwife' which focused on celebrating achievements, maternity learning events which focused on topics such as consent and never events. There were a series of sessions running in October in recognition of Black History month. There had been several staff led sessions for World Patient Safety day held within maternity services.

The service engaged with women with a baby friendly initiative and held breastfeeding drop-in groups as well as offering online antenatal breastfeeding sessions and specialist clinics held.

The service found ways to capture and engage with staff by making learning events more visual and interactive. For example, there was a moveable governance board that could be moved to each unit and tea and biscuits were offered when staff looked at the board to make the environment more relaxing.

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.

There were various quality improvement projects which had achieved good outcomes. The quality improvement project 'together we can save babies lives' had seen a reduction in the number of incidents related to undetected SGA babies and now have the best trust detection rate for small babies in six years.

A medicine management quality improvement project led by Florence Nightingale Windrush programme to improve adherence to administration of medicines. Since commencement of the project in September 2020 no serious incidents related to medicine errors have occurred.

In September 2020 the service received baby accreditation for their baby friendly excellent practice support of infant feeding and parent infant relationships.

Maternity

The Maple service developed in collaboration with North London commissioners and partners was developed for women whose trauma symptoms had a moderate to severe impact on their mental health. This was a pilot service designed to address a service gap in perinatal mental health. Maple offered psychological therapy and peer support through four distinct clinical pathways.

A quality improvement breastfeeding project was due to start in October 2021. This project aims to reduce inequalities by improving breastfeeding support as well as mothers' experiences and breastfeeding rates.

Outstanding practice

The Magnolia Perinatal Mental Health team won the NMC Excellence in Perinatal Mental Health award at the Royal College of Midwives annual awards in recognition of their multidisciplinary approach.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 service SHOULD take to improve:

- The trust should continue work to improve interpreting services for people who used the service.
- The trust should continue to find ways to improve staff wellbeing with regards to workload and support with their daily caseload.
- The trust should continue to improve the junior doctor's induction.
- The trust should continue to build upon the improvements made within the culture of the service. There were still pockets of concern that needed work.
- The trust should make sure the anaesthetist is present as much as possible for the morning handover meeting.
- The trust should continue ongoing work to improve bed occupancy rates.

Our inspection team

The inspection was led by one CQC inspector who was supported by an experienced obstetric specialist advisor and a midwifery specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

During the inspection we visited the labour ward, birthing centre, antenatal, maternity and triage day assessment unit, close observation maternal assessment and neonatal unit. We spoke with over 30 staff including student midwives, junior midwives, junior doctors, consultants, band 6-8 midwives and the leadership team. We looked at 13 sets of notes, attended morning huddles and interviewed the senior team via video conferencing technology.

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