Sandwell and West Birmingham Hospitals NHS Trust

City Hospital

Inspection report

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Date of inspection visit: 5 May 2021
Date of publication: 15/07/2021

Ratings

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

Our findings

Overall summary of services at City Hospital

Good ↑

We carried out this unannounced focused inspection because we had concerns about the quality of maternity services.

We did not inspect all core services rated as requires improvement at this trust because the services had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

See the maternity section for what we found:

- Staff had training in key skills, 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. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service and made sure staff were competent. Midwives and consultants worked well together for the benefit of women.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of women receiving care. 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:

- The service did not have enough staff to care for women and keep them safe.
- Not all midwifery staff felt respected, supported or valued by the senior leadership team.

How we carried out the inspection

We were concerned about maternity services at the trust following recent concerns raised by patients and whistle-blowers, which we received between July and September 2020, and information we received from the trust. Therefore, we carried out an unannounced focused maternity inspection at City Hospital on 5 and 6 May 2021.

We inspected clinical areas in the service, including the delivery suite, antenatal and postnatal wards, the antenatal clinic, the maternity day assessment unit and community services. We spoke with 32 staff, including service leads, midwives, community midwives, medical staff, and student midwives. We reviewed six sets of patient records and six prescription charts and observed staff providing care and treatment to women.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. As we carried out a focused inspection related to the concerns raised, this did not include all our key lines of enquiry. As a result of this inspection, we rated safe and well-led as good, and the other key questions remained the same as per our previous inspection.

Our findings

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 (inpatient services)

Good

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

- Staff had training in key skills, 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. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service and made sure staff were competent. Midwives and consultants worked well together for the benefit of women.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of women receiving care. 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:

- The service did not have enough staff to care for women and keep them safe.
- Not all midwifery staff felt respected, supported or valued by the senior leadership team.

Is the service safe?

Good

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

- 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.
- 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.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each woman and took action and removed or minimised risks. Staff identified and quickly acted upon women at risk of deterioration.

However:

- While midwifery staff had the right qualifications, skills and training, managers found it challenging to safely staff the department at times. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.
- The service had not made sure all staff had completed mandatory training in key skills.

Mandatory training

Maternity (inpatient services)

The service provided mandatory training in key skills to all staff, however they did not make sure everyone completed it.

Staff did not always receive and keep up to date with their mandatory training.

The trust's mandatory training compliance target was 95%. The overall compliance rate for maternity staff as of May 2021 was 69%. The clinical education team designed and co-ordinated training to ensure the training content was in line with staff training needs, was evidence-based, consistent with national and local guidance and adapted in response to incidents.

Managers had action plans in place to address low compliance. Following our inspection, as of 24 June 2021 staff were 80% compliant with mandatory training. This include training all levels of staff throughout the trust were required to complete and the target was 100%. Midwives were 95% compliant with professional training which was the target.

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

Topics included medicine management, infection control, resuscitation of the new-born and equality and diversity. The service ran regular skills drill training. This was in line with The Safe Births report which stated, 'Staff that work together must train together'. Scenarios included, maternal collapse, cord prolapse, transfer from induction of labour suite to delivery suite, baby abduction, bradycardia on the Antenatal Day Assessment Unit (ADAU), transfer to delivery suite, maternal collapse in pool on the midwife led unit, transfer to delivery suite and eclamptic fit. This meant managers had processes in place to assess clinical skills as well as communication and teamworking. Staff completed 'Practical Obstetric Multi-Professional Training' (PROMPT) training. This is an evidence based multi-professional training package for obstetric emergencies. This meant staff received training to reduce preventable harm to mothers and their babies.

In addition to PROMPT the unit ran trolley dashes to include a Multi-Disciplinary Team (MDT) in practical learning. Areas covered included bladder filling, vaginal examinations, Post-Partum Haemorrhage (PPH) guidelines and PPH, major obstetric haemorrhage and roles and responsibilities in emergencies. In terms of obstetric emergencies, the service tailored training based on risks that were frequent such as shoulder dystocia and cord prolapse. The service could evidence learning from this training. For example, feedback in the management of maternal obstetric haemorrhages was evidenced by reduced intensive care admission, reduced blood transfusions and reduced use of a machine that provided a rapid assessment of clot development. Leaders also found that after shoulder dystocia training, there was a reduction in admissions to the Neonatal unit (NNU) due to fractures.

The service had increased the number of skills drills training on site. This happened every two weeks. It was run by the midwifery education team, and they reported back to the governance team. There was also a trust simulation lab which was used by the obstetric anaesthetists. During the pandemic, PROMPT carried on virtually. The midwifery education team shared learning with teams and the governance team. Managers ensured training was not interrupted during the pandemic. Due to the ceasing of face-to-face interactions, leaders developed an online package which covered fatal monitoring, human factors, immediate care of the neonate, the saving babies lives care bundle V2 (CO monitoring and smoking), fetal growth restriction, electric fetal monitoring, postpartum haemorrhage, maternal collapse and cardiac arrest and Covid-19 and team working.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

This formed part of the mandatory training day for all staff and was part of the professional training day for midwives. Midwives were 95% compliant with this training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Training compliance was monitored by the clinical educators and line managers, actioned with individuals, monitored at workforce level, confirmed and challenged by directorate leads and monitored through staff meetings and the human resource director's office. Regular meetings took place to discuss the most recent mandatory training report for maternity services. The educators attended to see what additional support was required to improve the compliance of mandatory training, reminders were included through a variety of communication channels such as staff newsletters and action plans were produced to address areas on non-compliance.

Staff were able to block a week every year to compete mandatory training, which had been mapped before the pandemic. This had been reinstated in April 2021. Staff received reminders when training needed refreshing at 6, 3, 1 month and then a weekly warning.

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.

Medical and midwifery staff received training specific for their role on how to recognise and report abuse.

As of 11 May 2021, the Maternity & Perinatal Medicine compliance rates showed full compliance for Level 1 Safeguarding Children, 96% for Level 2 Safeguarding Children and 95% for Level 3 Safeguarding Children.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

For example, staff risk assessed women who may have been at a greater risk of Covid-19, during the pandemic including those from Black, Asian and Minority Ethnic (BAME) backgrounds, and made appropriate arrangements.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff demonstrated how they would recognise safeguarding concerns for adults and children.

There was a vulnerable women's team, Female Genital Mutilation (FGM) midwife and safeguarding team. The FGM midwife carried out a pre-pregnancy FGM pilot which was based at a GP surgery.

There was an FGM clinic for pregnant ladies situated at both City and Sandwell Hospitals run by a specialist midwife. The service provided care, support, help, advice, safeguarding and general information and was dedicated to improving standards of life holistically for women who had endured this practice. There was also a clinic for non-pregnant women, which took place at a local health centre which offered the same care and treatment. Every year on 'Zero Tolerance Against FGM Day' staff raised awareness amongst colleagues and communities of the implications, effects and dangers of FGM. It was also an opportunity to share information about the clinics and care available for women and girls who

had undergone this procedure. There was also a mental health midwife and two teenage pregnancy midwives. The leadership team had put in a business case for funding for a domestic violence midwife. The safeguarding midwife was leaving, and this post had been advertised. They were also advertising for two further band 6 midwives. One of the mental health midwives also dealt with substance misuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff could contact the midwifery safeguarding team for advice and support. They provided advice, training and quality assurance of the safeguarding and court reports. Staff accessed safeguarding policies on the trust's intranet and requested further support from the trust's safeguarding team if necessary. Safeguarding vulnerable adults' posters were on display throughout the maternity unit with useful contact numbers for staff to access support.

Staff followed safe procedures for children visiting the ward. Only the children of mother's who had given birth on the unit could visit prior to the pandemic.

Staff followed the baby abduction policy and undertook baby abduction drills.

Safety processes were in place to lower the risk of baby abduction. Visitors were required to be let into the ward through a secure door buzzer that staff operated. Babies wore electronic tags.

We reviewed a recent baby abduction drill. Learning points included "Everyone took the scenario seriously – the majority of staff were unaware of it being a drill but the staff members who were aware continued fully involved". We saw action plans were put in place to address areas of non-compliance. For example, managers found "The cot space was not cordoned off as per policy'. This was done to ensure it is preserved as a crime scene". Managers advised all staff to take the time to re-familiarise themselves with the "guideline following alert for a missing baby, child or young adult in the inpatient area". Leaders reviewed their safeguarding procedures during the pandemic. Leaders identified risks to their safeguarding procedures on their risk register due to the pandemic. They identified that the risk that reduction in face-to-face midwifery appointments due to Covid-19 could mean that staff missed opportunities to identify and escalate safeguarding concerns. Action points put into place included face to face appointments reintroduced to high-risk women at all ante natal appointments. This ensured safeguarding was robust in the face of disruptions to their usual service.

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. However, hand sanitising gel was not fully stocked in each clinical area entrance for staff and patients to use such as the entrance to the labour ward.

The service generally performed well for cleanliness.

We reviewed the full departmental cleaning audit for February 2021. This was a trust wide audit and they audited one area of the maternity department every month. This looked at areas such as radiators, electric items, hand hygiene,

alcohol rub gels, commodes and showers. The service showed 99% compliance overall. Where areas of noncompliance were found, action plans were put in place. For example, where a water shore cover was not fixed and needed replacing, managers had reported this to the estates department. This had been fixed. Weekly cleaning audits from February to May 2021 showed compliance in all areas.

Other audits included weekly matron audits and daily spot checks by the manager. All audits continued throughout the pandemic. The matron also carried out a five by five audit daily. This was a cleanliness check of five pieces of non patient equipment at five pm every day.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

All the areas we visited showed cleaning was up to date. Cleaning audit data supported this.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff appropriately used personal protective equipment such as aprons and gloves. We saw these were readily available, which staff confirmed. Staff were 'bare below the elbow' in accordance with the trust's infection prevention and control policy. We reviewed hand hygiene audits completed between March and May 2021. These showed full compliance for all grades of staff across all wards.

Processes were in place to keep patients and staff safe during the pandemic the department introduced additional IPC measures. For example, during labour, one birthing partner could attend within the hospital premises and on arrival there was a requirement to undertake a Lateral flow test (rapid COVID-19 test) before all antenatal appointments. Staff wore masks and socially distanced on the wards.

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

Equipment we checked was clean and had 'I am clean stickers' to confirm when staff had last cleaned them.

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.

Women could reach call bells and staff responded quickly when called.

Call bells were at places where patients were at their most vulnerable, such as beside their bed and in the bathroom. This allowed women to alert a midwife or other health care staff member remotely of their need for help.

The design of the environment followed national guidance.

For example, the delivery suite was located on the same floor and near the obstetric theatres and neonatal unit should patients require transfer to these areas.

Staff carried out daily safety checks of specialist equipment.

For example, staff checked adult and neonatal resuscitation equipment each day in all areas of the maternity department. This was in accordance with the trust's policy. We reviewed the audits and found action plans were put in place to address areas of non-compliance. The service followed systems and processes to ensure staff were meeting their meeting their legal obligations and following good practice in relation to the environment. Staff completed regular environmental audits and put action plans in place to address areas of non-compliance. Equipment safety concerns were shared with staff. For example, the May 2021 inpatient communication poster shared 'there will be a reintroduction of room checklists on delivery suite to help identify shortfalls and misplacements".

The service had suitable facilities to meet the needs of women's families.

However, we found the equipment store door propped open with a waste bin on the labour delivery ward. The room contained oxygen cylinders and a controlled drug cabinet. The corridor outside contained cages full of cardboard boxes. This was a fire risk. We raised the risk with management, and they immediately put it right. The service had enough suitable equipment to help them to safely care for women and babies. Staff disposed of clinical waste safely. Women choosing to have their baby in hospital could use rooms with home-like surroundings or bring personal pillows or other items to make the environment more comfortable. At City Hospital, the Serenity Midwifery Birth Centre was a purpose-built facility that looked and felt homely to make women feel comfortable and relaxed. The transfer lounge provided women with a comfortable environment where they could wait for their relatives to collect them. There were refreshments, baby care facilities, TV and staff on hand to help them prepare for going home.

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.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used The Maternity Early Obstetric Warning System (MEOWS) tool. The early warning scoring system was a simple, quick-to-use tool based on routine physiological observations. The scoring of these observations provided staff with an indication of the overall status of the patient's condition. Prompt action and urgent medical review when indicated, allowed for appropriate management of women at risk of deterioration. This was evidenced in the records we reviewed. Staff took part in regular skills drills training. This meant they were trained to identify and respond to emergency situations within maternity and felt confident with responding to emergency situations in the hospital or the community including childbirth taking place at home, in midwifery-led units and out of hours.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff completed patient risk assessments to help them to choose their preferred place of delivery, recommend further investigations and provide them with an individualised care plan. This included whether a patient was recommended for midwifery or consultant-led care and if referrals to other professionals in the multidisciplinary team were required. Patients' needs were assessed at triage on arrival to the maternity unit. Records we checked demonstrated community staff had conducted full risk assessments of patients at their first booking visit. These included documenting a patient's social history. Risk assessments were updated on every contact and documented on the maternity IT system. A day assessment unit was staffed to care for women whose pregnancies were considered 'high risk'. This allowed staff to monitor patients closely but without having to admit them into hospital. The number of visits differed for each person, according to their needs. This ward was open 8am to 8pm, Monday to Friday. However, staff told us there were delays in seeking medical reviews as they did not have a dedicated consultant and had to rely on the labour ward consultant.

Maternity (inpatient services)

Women could access the maternity triage unit. Staff on the unit assessed women who were more than 22 weeks into their pregnancy as well as women who were 14 days post-delivery who had an urgent clinical complaint relating to pregnancy or delivery.

Staff knew about and dealt with any specific risk issues.

Staff used a tool known as the sepsis six bundle to assess women in maternity. In records we reviewed staff had used this pathway appropriately. Maternity staff we spoke with were knowledgeable about sepsis and how to escalate the care of women with deteriorating conditions. Staff understood how to access the sepsis guideline on the trust's intranet. Staff monitored, recorded and escalated concerns regarding cardiotocography (CTG) reviews to protect women and their babies from abuse and avoidable harm. A CTG measures babies' heart rates and monitors the contractions in the uterus. Staff used a CTG before birth and during labour, to monitor the baby for any signs of distress. As of May 2021, 92% midwives and 81% of medical staff were compliant with the CTG training. The target was 95%. Consultants led a morning audit which was an MDT review of all cases that had required surgical intervention in the last 24 hours. This included review and discussion of CTG's and an interactive CTG training board. Staff followed processes to reduce the risk of venous thromboembolism during pregnancy and the puerperium. Venous Thromboembolism (VTE) is a term referring to blood clots in the veins, which is an underdiagnosed and serious, yet preventable medical condition that can cause disability and death. The trust set a target of 95% for staff completion of VTE assessments. This was documented on the maternity dashboard. We reviewed the compliance from October 2019 to May 2021. Staff achieved 93% compliance in this area.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health).

A specialist mental health midwife provided expert advice to colleagues and to women and their families and acted as a resource on issues relating to the identification, assessment and management of mental health problems during pregnancy or after birth. The trust had dedicated support at both the main hospitals for patients suffering from mental health illnesses. The Rapid Assessment Interface and Discharge team at City Hospital was made up of a multi-skilled team that provided a comprehensive assessment of a person's physical and psychological wellbeing. Team members visited patients in wards across the hospital, and in A&E. They provided a psychiatric liaison, and brought together practitioners from other mental health specialities, including substance misuse in one team so that all patients over the age of 16 could be assessed and treated or referred appropriately much earlier. At Sandwell Hospital mental health liaison nurses provided support for patients with mental health needs.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff shared key information to keep women safe when handing over their care to others.

Risk assessments included mental health assessments. Staff had accurately completed risk assessments in all the records we reviewed. We attended a handover, which we saw followed a Situation Background Assessment Review (SBAR) format and was held away from patient areas. SBAR is a technique that can be used to facilitate prompt and appropriate communication. This was well attended by a range of multidisciplinary staff including consultant obstetricians, consultant anaesthetists, midwives and registrars.

Shift changes and handovers included all necessary key information to keep women and babies safe.

We saw staff discussed all appropriate information. Daily safety huddles had been recently set up in all ward areas. Areas discussed included harm of the week, safety concerns from the previous 24 hours, patients needing urgent concerns from the MDT, equipment issues, staffing and discharge issues and patient flow.

Midwifery staffing

While midwifery staff had the right qualifications, skills and training, managers found it challenging to safely staff the department at times. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Managers found it a challenge to ensure the service had enough midwifery staff to keep women and babies safe.

Leaders had identified this risk and had action plans in place to address this risk. For example, they had offered 21 third year students positions and 17 had accepted. The consultant midwife was scoping options for working in partnership with independent midwives and community midwives were to be offered an uplift to their salaries. There were known issues within community midwifery including recruitment and retention issues. This was in keeping with national maternity services and the midwifery profession. The existing workforce at the trust also had its own issues with succession planning and team development inclusive of high attrition rates. This meant there was a risk regarding the ability to fulfil local and national standards. A community midwife transformation programme had been put in place with the aim to 'Build a safe and secure infrastructure within Community Midwifery'. Serenity Suite staff felt staffing of the delivery suite took priority over the staffing of the Serenity suite. Staff told us this had put a strain on the relationship between Serenity Suite and delivery suite staff. The head of midwifery was aware of this and had set up mediation between the two departments. Maternity staff worked 12-hour shifts with some staff working shorter days. The department aimed to ensure there was a supernumerary delivery suite co-ordinator on every shift. Some midwives said they sometimes struggled to meet this. Action plans were put in place to increase compliance. This meant women may not have always had a good experience of care. It also increased the likelihood of problems for women and their babies. We reviewed the data for November 2020 to April 2021. There were no occasions where one to one care was not achieved on delivery suite. There were four occasions where one to one labour was not achieved on the Serenity suite.

Managers accurately calculated and reviewed the number and grade of midwives, and healthcare assistants needed for each shift in accordance with national guidance.

A Birthrate Plus assessment had been carried out in the department. Birthrate Plus is a workforce-planning tool used in maternity units. The last Birthrate Plus (BR+) review was undertaken in 2019. This showed a deficit of 11 Whole Time Equivalent (WTE) midwives. Since this review the service had reconfigured the workforce model in community, in line with the national approach of change to an 80:20 spilt of midwives to band three maternity support workers (included in midwife numbers in BR+). The trust had also seen a decline in births in line with a national downward trend. However, staff felt workforce should not be based on birth itself, as the population the trust served required enhanced antenatal and postnatal care which made up the larger aspect of maternity care. The trust invested in supporting their maternity support workers to work towards a band 3 level. A full competency passport was created in line with Health Education England guidance to upskill them. Leaders identified that this would however alter the BR+ requirements and another review had been requested. The service was currently working through workforce models as they worked towards moving to the new hospital site. All new posts were fully rotational to provide fluidity in staffing and reduction of risk, allowing staffing moving forward to be based on real time acuity and capacity without generating risk. Preceptorship

was to be a two-year programme to cover all areas and address skill mix issues. Ongoing recruitment was taking place to ensure both substantive and fixed term to cover parental leave and ensure provision to cover emerging vacancies. The service had an escalation process where an on-call manager would be available for staff to contact for advice regarding staff deployment and any other concerns 24 hours a day, seven days a week.

The ward manager could adjust staffing levels daily according to the needs of women.

Managers carried out regular and ongoing monitoring of the activity and staffing to identify trends and causes for concern. This was supported by a robust policy for escalation in times of high demand or low staffing numbers. Daily staffing meetings were led by the senior team to ensure flexibility and fluidity to meet acuity and capacity.

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The number of midwives and healthcare assistants matched the planned numbers.

The midwife to birth ratio was 1 to 23. Managers followed an escalation policy to ensure safe staffing. This provided staff within the multidisciplinary team with guidance on how to manage beds and staffing levels to ensure services were maintained during times of high activity or staffing shortfall within the service.

The service's vacancy rates.

As of 6 May 2021, within the nursing and midwifery registered 12.63 full time equivalent (FTE) was against a neonatal nursing line, with 18.88 FTE against midwifery, with 10.85 FTE within community midwifery. Leaders had actions in place to address this shortfall. For example, an incentivised options paper had been approved by group. Actions had been taking to ensure women and babies were kept safe. For example, homebirths were suspended due to staffing. Staff explained to women the reason for suspending this service and explored all other options including the midwife led unit.

Since the inspection seventeen interviewees had accepted offers to start midwife roles from July 2021 onwards.

The service's turnover rates.

Staff told us low staffing rates and a negative work culture negatively affected staff retention. Several midwives had recently left the department to work in other local trusts. We reviewed the human resources turnover themes from 1 November 2020 to 31 April 2021. Twenty-six staff members had left the trust and themes were lack of support, no confidence that they will be listened to and heard, views that recruitment into roles was not fair or consistent and kindness was not always demonstrated. The highest turnover was for community midwives. Managers had put actions plans in place to address these issues. For example, with support from the trust, they had brought in an external company to do work around the culture and had incentives in place to attract new recruits.

The service's sickness rates.

Maternity (inpatient services)

There were 19 open sickness cases (maternity and perinatal) as of 6 May 2021. Twelve of these were due to long term absence, two were under review, five were short term absence, three had returned to work and zero for planned return to work. The directorate held monthly confirm and challenge meetings which included support of ongoing cases and proactive reviews of health and wellbeing. Staff from the human resources department attended relevant governance to ensure oversight and offer support in this area.

Manager used bank staff to support high standards of patient safety and care. If service did not have enough staff on the wards, due to increased demand, sickness or staff shortages, they needed the support of bank staff, which were usually available.

Managers limited their use of bank staff and requested staff familiar with the service. Manager only used bank staff. This meant bank staff cost the trust less than agency staff and improved a patient's continuity of care.

Managers made sure all bank staff had a full induction and understood the service. Bank staff consisted of substantive staff in the service.

This meant they had received inductions and were familiar with the service.

Medical staffing

The service 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 enough medical staff to keep women and babies safe.

The delivery suite had 96 hours of obstetric consultant presence each week, which was above the recommended 60 hours of cover for the number of births at the trust. Consultants were resident onsite Monday to Friday 8.30am to 8.30pm and at a weekend until 15.30. They then provided cover as part of an on call rota from home.

There was regular consultant presence and consultants conducted regular ward rounds. Twice daily consultant rounds took place at 09.00 and 17.00 Monday to Friday and 09.00 and 15.00 on weekends. The maternity service met the recommended hours of obstetric consultant presence for the number of deliveries at the trust in accordance with the ‘Safer Childbirth/RCOG: The Future Workforce guidance (May 2009)’. A consultant was present on the labour ward for 12 hours (08.30-20.30) Monday to Friday. Consultants were resident on call from 20.30 to 08.30 Mondays and Tuesdays. Dedicated consultant ward rounds took place a minimum of twice a day with the labour ward team (junior doctors/ midwife Coordinator). All management plans were recorded on the maternity IT system. Consultants provided support to junior trainees in decision making and management of complex cases. Anaesthetic cover was available 24 hours a day, seven days a week on the delivery suite. Obstetric anaesthetists were free from other duties during this time. Medical staffing, rota and reviews were monitored through directorate leads.

The medical staff matched the planned number.

Managers used locum doctors to cover gaps in rotas due to absence or recruitment and retention problems.

The service’s vacancy rates for medical staff.

The service currently held gaps in both the junior and senior rota's due to areas such as incomplete deanery fill, maternity leave, and staff reallocation during the pandemic. As of 6 May 2021, the total directorate vacancies included the full spectrum of workforce, and of the 7.82 full time equivalent (FTE) medical vacancies, 7.26 FTE sat within obstetrics and gynaecology. These gaps were filled with NHS locum long term or short term to ensure cover and safe staffing out of hours. Locum cover was in place for a consultant shortfall, but consultant cover was maintained at the 98 hours per week required resident on unit cover.

The service's turnover rates for medical staff.

As of May 2021, there were three vacancies, which was comparable to this time in the previous two years. There were also no abnormal turnover issues with any grade of medical staff.

Managers could access locums when they needed additional medical staff.

This ensured cover and safe staffing out of hours. The service had locum cover for a consultant shortfall, but consultant cover was maintained at the 98 hours per week required resident on unit cover.

Managers made sure locums had a full induction to the service before they started work.

This meant they were showed how to work safely in their new environment.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

This was reflected in the staffing figures and staff confirmed this.

The service always had a consultant on call during evenings and weekends. The out of hours on call was covered and weekend working was 08.30 to 15.30 resident: thereafter on call.

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's notes were comprehensive, and all staff could access them easily.

Staff used an online portal and app that allowed women to access their maternity records over the internet through their PC, tablet device or mobile phone. We reviewed seven sets of maternity patient records. All records were clear to navigate and contemporaneously completed. For example, records accurately recorded patient's choice. They also evidenced staff had held multidisciplinary discussions to ensure patients received patient-centred care as described in their care plans. Referrals to specialist services were clearly noted.

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

The maternity IT system ensured smooth transition between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.

Records were stored securely.

We did not see any data breaches during our visit. Staff stored records in lockable trollies and filing cabinets next to the midwives' station. Managers had recently put in place processes to ensure documentation standards were being met. All managers completed ten documentation audits for each area of the service. Managers triangulated documentation themes found in incident reporting data with their known areas of high risk such as staffing levels. For example, they recently found a 'lack of documentation in maternity IT records; likely due to availability of staff to scribe and lack of administration of uterotonics during MOH'. Action plans were put in place to address this risk. For example, education was carried out with staff relating to scribing in emergencies with the aim of empowering support staff and students to feel confident in supporting with scribing to allow midwives to further assist with additional support during the emergencies. The education team had taken this as a focus board to deliver training around the unit. They were also currently in the process of improving the resuscitation 'scribe' sheets to help make them easier to use with prompts for staff on the algorithm of managing.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Managers identified themes from incident reporting data to improve learning from medicines-related patient safety incidents. This ensured staff were following guidance and minimised patient harm. Medicines-related patient safety incidents are unintended or unexpected incidents that are specifically related to medicines use, which could have, or did lead to, patient harm. These include potentially avoidable medicines-related hospital admissions and re-admissions, medication errors, near misses and potentially avoidable adverse events.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

The Medication Administration Record (MARS) charts we reviewed were mostly clear and accurate and there was an immediate record of all medicine administered. Signatures were clear and legible. Staff stored medicines securely in all clinical areas we visited. Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day. Medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within their use by date. Staff kept records of medicines fridge temperatures and ambient room temperatures of their medicine rooms on the delivery suite and postnatal ward. All medicines we checked were locked in cupboards in locked rooms. Access to the room was accessible through a digital lock.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely.

For example, the education governance and risk team shared alerts through a variety of channels such as on the electronic share point which all staff could access.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff gave women the right drug, at the right dose, at the right time.

Maternity (inpatient services)

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.

Staff reported a total of 663 incidents in the last quarter. Of these, 61% of incidents were patient safety incidents. The top three incidents reported were unexpected transfer to the neonatal unit, postpartum haemorrhage over one litre and screening incidents.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

For example, staff reported 118 staffing incidents in the previous six-month period. This reflected what we found on our inspection.

Learning from incidents was shared with staff.

The Education, Governance and Risk (EGR) team worked closely together. They reviewed all 72-hour reports and produced monthly newsletters to all staff. Staff in the EGR team said the obstetric and neonatal risk leads worked closely with the team. The EGR team carried out regular 'trolley dashes. This involved taking a trolley with learning equipment and visiting staff on the wards. The content was in response to incident themes. The governance team produced a 'risky business' newsletter which talked about themes from complaints, risks, any updates to guidelines. There was also a community newsletter called 'family ties' to keep community staff up to date with the rest of the maternity team. The team had also set up a cloud-based software system for shared learning which held information.

The service had reported not never events on any wards.

Managers shared learning with their staff about never events that happened elsewhere.

The risk and governance team worked collaboratively with other risk teams in the region as part of the local maternity system risk work stream. This meant they shared information system wide.

Staff reported serious incidents clearly and in line with trust policy.

Staff felt able to raise concerns if required; however, some staff reported they often did not have time to complete incident reports due to lack of time due to the staffing levels in the department. In addition, some staff did not always raise incident reports relating to staffing levels as they told us they had raised incidents in the past and had seen no improvements. The risk governance team said this was evidenced with lack of incidents reported for staffing shortfalls amongst community staff, despite staff telling us this was their main area of concern.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Maternity (inpatient services)

Staff at all levels demonstrated a good knowledge of the Duty of Candour and understood the main principles of the regulation. The service demonstrated how they met the Duty of Candour regulation. The duty requires health service bodies to act in an open and transparent manner when things go wrong. The maternity service monitored how many occasions the Duty of Candour had been applied and in what way the duty had been applied, whether verbal or written or both.

Staff received feedback from investigation of incidents, both internal and external to the service.

For example, leaders shared information through a community newsletter, emails and daily huddles which were documented and saved to shared computer folders/drives, professional update forums, community quality improvement half days and team meetings. Managers created a 'Pledge to Patient' safety folder and kept it in the labour ward. The folder had a safety plan on a page with a chosen safety theme every month. The aim was to make the staff aware of the lessons learnt from incidents. Staff were required to go through the folder and sign the page as an evidence of learning. The governance team disseminated learning in different ways, such as through newsletters and electronically. Staff could attend open meetings for their own learning. For example, staff discussed learning from incidents and how policies had changed because of the learning in the perinatal mortality meetings. Where they could not attend meetings, lessons learnt were shared through other means such as through the 'inpatient communication' posters. For example, the May 2021 poster shared "Following an incident in community where a family were sent home with the wrong baby's birth registration, please ensure we check paperwork and positively confirm identity when handing this out". Staff were also encouraged to attend the Quality Improvement Half Days (QIHD). These had an open agenda so that obstetric, midwifery and risk issues could be discussed. This was now a mandatory session. Staff discussed areas such as audits and action plans, complaints and themes such as returning to work from coming back from shielding. There was also a 'you said, we did' newsletter. This involved informing staff about how their views and opinions had influenced change.

Staff met to discuss the feedback and look at improvements to patient care.

All signed off Serious Incidents (SIs) (trust wide) were shared at the monthly executive quality committee and were reported quarterly through to board. Weekly incident review meetings took place.. An online link was available for this meeting to encourage representation from all areas to identify patient safety issues and ensure oversight of themes and trends of incidents. Staff also discussed incidents and themes in arenas such as the listening into action and perinatal morbidity meetings which were open to all staff.

There was evidence that changes had been made as a result of feedback.

For example, the Healthcare Safety Investigation Branch (HSIB) made a recommendation relating to fluid balance and the robustness and accuracy of recording. In response, these issues were a focus of the twice daily safety huddles for two weeks to capture most inpatient staff (from consultants through to maternity support workers). Leaders said that this was very well received and from reviews since this started it had been evident that fluid balance was being recorded appropriately on the maternity IT system. There was also focus on a risk identified in relation to the administering of aspirin and the documentation to support compliance once the aspirin risk assessment has been completed. Posters were produced for the clinical areas to capture the midwives from a visual perspective. This was also a focus during the first 'Saving Babies Live's study day. Further learning was in relation to scribe documentation; this was a focus of the education team. New neonatal scribe sheets were created and were available in the clinical areas to act as a prompt and make things easier during resuscitation. The Education, Governance and Risk Team shared area folders were live on the

trust intranet and accessible for all staff. Managers identified themes from reported incidents. For example, they identified an increase in missed screening. Actions were put into place to address this risk. For example, newsletters were sent to all staff to ensure staff are aware of when to refer women to the screening team. The triage lead was developing a flowchart for un-booked women who attended triage.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations.

For example, all perinatal mortality cases had a 72-hour review where staff looked for trends, themes or gaps in care. All perinatal mortality cases were then reviewed through the Perinatal Mortality Review Tool (PMRT) by a multidisciplinary group, which included external experts and parent's views and questions. Duty of candour was discussed as an agenda item in the governance meetings. Outstanding actions were discussed, and action plans out in place to address them. Managers completed a Root Cause Analysis (RCA) to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. We reviewed the previous three RCA's completed by the service. They looked at what, why and how it happened? They identified areas for change and developed recommendations, with the aim of providing safe patient care. Involvement and support for patients and relatives formed part of the RCA process.

Managers debriefed and supported staff after any serious incident.

When there had been maternal deaths there had been involvement from occupational health and specialised counselling. We saw evidence that occupational health had arranged an event in maternity, which was very well attended following a recent maternal death. It was an opportunity for staff to off-load, talk about stresses and how to cope in the aftermath of the maternal death with their colleagues. They were planning another learning event for another incident. The unit had an 'IR2' incident reporting process in place to report positive feedback to staff and commend good practice.

Involvement and support of staff.

The RCA process included involvement and support provided for staff involved.

Managers analysed incident data and triangulated themes with areas of high risk. For example, they analysed six months' worth of incident data and triangulated this with staffing levels (they flagged times of risk using a red/amber/green flagging system) and reviewed themes. They completed 63 '72-hour reviews' on the back of incidents that had occurred. Of these 62 reviews, they identified seven days where high/ 'red' acuity correlated with low staffing. Of the seven incidents that occurred on these 'red' days, there were only two cases that identified possible gaps in care and /or themes that may have been because of lack of staffing. In relation to medication errors, none of the errors reported were due to staffing issues, instead the theme appeared to be related to poor staff handovers.

Safety Thermometer or equivalent

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Prior to the Covid-19 pandemic staff used the safety thermometer data to further improve services.

Maternity (inpatient services)

The trust used the Maternity Safety Thermometer to monitor the safety performance of the service over time. This recorded harm and the proportion of patients who have experienced harm free care. It measured harm from Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety. The safety thermometer supported improvements in patient care and experience, prompted immediate actions by healthcare staff and integrated improvement measurement into the service's daily routines. The department recorded this data on a single day every month (every first Wednesday of the month) for all postnatal patients and their babies. The results were uploaded to the website by the Maternity Risk & Governance team using the data collection tool. The data collated from the safety thermometer was reported into the Maternity and Neonatal Governance and Governance Board. Learning from feedback was highlighted through the patient experience QIHD presentations or immediately if patients raised them. The Head of Midwifery (HoM) said they were planning to start using the safety thermometer again from summer 2021.

Is the service effective?

Inspected but not rated

This was a focused inspection. Because of its limited scope, we did not inspect all elements of this key question. You can view previous ratings and reports on our website at www.cqc.org.uk.

Evidence based care

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The maternity service took part in national benchmarking clinical audits such as the Maternal, Newborn and Infant Clinical Outcome Review Programme (part of MBRRACE Audit) of UK Perinatal Deaths. All actions to reduce morbidity and mortality levels of the service in response to MBRRACE results were fed into the saving babies lives care bundle and Clinical Negligence Scheme for Trusts (CNST) incentive scheme. Evidence based care was evidenced from 24 weeks in relation to fetal growth monitoring in the records we checked. We reviewed a sample of the maternity guidelines including the fetal monitoring guide in labour. They were up to date, clear, useful guides, instructions, or explanations that were easy for staff to understand and follow. We found good areas of practice. For example, there was explicit mention that if the midwife in charge had any concerns about the management plan recommended by a junior doctor that they should contact the consultant directly. This was clear and supported support safe practice. Structure for oversight of National Institute for Health and Care Excellence (NICE) guidance sat corporately with the multidisciplinary guideline group in maternity services. The guideline group reported into the directorate risk and governance group and this was reported through the governance system such as the group governance board and executive quality committee. The education governance and risk team shared a quarterly bulletin with all staff. This included a section on audits and guidelines which had been updated the previous month.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

Maternity (inpatient services)

The service participated in relevant national clinical audits. For example, the National Neonatal Audit Programme, Each Baby Counts, annual MBRRACE – UK audit, the Twins and Multiple Births Association (TAMBA) audit. This meant leaders benchmarked their service provision and performance against national standards and key performance indicators.

Outcomes for women were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women's outcomes.

Managers produced action plans to make improvements. For example, women fed back that experiencing induction of labour on the delivery suite was inappropriate. Managers therefore opened a self-contained induction suite. Managers said they had received positive feedback from women and staff following the changes. In March the Emergency Lower Segment Caesarean Section (EMLSCS) rate was 15.0% and the Elective Lower Segment Caesarean Section rate (ELSCS) rate was 12.3% with a total rate of 27.3%. This was below the services average total rate year to date which was 29.7% against a national average of 30%. All EMLCS's from the previous 24 hours were reviewed within the multi-disciplinary team handover each morning to ensure correct and timely care pathways and decision-making had taken place. Trends or clinical issues from these reviews were escalated to the risk and governance team and/or Labour Ward lead for further assessment. The Avoiding Term Admissions to into Neonatal Units (National ATAIN) scheme required all trusts to have admission rates of term infants below 6% by March 2019. The service had been working through a steering group to reduce term admissions and had achieved a reduction the criteria for hypoglycaemia and hypothermia. The highest proportions of babies were admitted for respiratory distress, with the top three indicators being Prolonged Rupture of Membranes (PROM), infection and presence of meconium. The ATAIN group had brought about change to action these with the introduction of new guidelines on the management of PROM, the opening of the induction bay to support improved acuity and capacity and therefore flow on delivery suite. All term admissions were reviewed by a multidisciplinary panel and outputs were monitored by the directorate and shared at quality improvement half days with staff.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Medical staff carried out a range of local audits and used the data to make improvements to the service. For example, an audit showed that anaemia was linked to major obstetric incidents. This led to the purchase of a that staff used as a point of care coagulation monitoring device in patients with massive haemorrhage. Other audits included bladder injuries, evaluation of intrapartum care of babies admitted to NNU at term due to meconium-stained liquor, outputs from the ATAIN programme ('avoiding term admissions into neonatal units' to reduce avoidable causes of harm) and term induction of labour. These highlighted areas of good practice and areas of risk. Medical staff carried out an audit to measure the effectiveness of enhanced recovery in obstetric surgery. Aims of the audit included to determine the length of stay following an elective caesarean and to determine whether enhanced recovery in obstetric surgery improved the length of post hospital stay compared to those on a standard pathway. Recommendations included to give women an enhanced recovery leaflet at the same time as discussing caesarean section and to confirm during pre-operative assessment and provide a carbohydrate drink. Plans included further audits. This showed medical staff investigated whether the healthcare being provided was in line with standards to inform care providers and patients know where their service was doing well, and where there could be improvements.

Managers shared and made sure staff understood information from the audits. Improvement is checked and monitored.

As of April 2021, the perinatal mortality rate was higher than the national average. Overall corrected perinatal mortality rate was 9.8 per 1000. This remained higher than previous months. This was mainly due to the lower number of births in the trust monthly compared to previous years (407 in March 2021). Perinatal Mortality (PNM) is defined as the loss of a foetus in-utero after 24 weeks gestation or a neonatal death which occurs up to 28 days of life. As well as these cases, the

service also submitted data on any 22-23+6-week gestation birth to MBRRACE-UK as mandated, although these cases did not contribute to the national or individual Trust PNM data outcomes. MBRRACE-UK also defines a PNM loss as being less than 400g birth weight and excludes terminations of pregnancy. We spoke with the clinical director who told us their population had significantly higher than average births in minority ethnic groups, Black and African and Asian/South Asian groups and that these are known risk factors for higher PNM. All cases from January had a 72-hour reviews where no trends, themes or gaps in care were identified; all cases were then reviewed through the perinatal mortality review tool (PMRT) by a multidisciplinary group, which included external experts and parent's views and questions. Audit results and action plans were shared with staff through forums such as mandatory quality improvement half days,

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.

The right staff with the right skills cared for women and their babies. This was demonstrated through their competencies, professional registrations, and ongoing supervision. Leaders had put together a preceptorship programme. This was a two-year programme to cover all areas and address skill mix issues. A full competency passport was created in line with Health Education England guidance to upskill the maternity support workers.

Managers gave all new staff a full induction tailored to their role before they started work.

Junior midwives and newly qualified band 5 midwives rotated, were assigned a buddy and were supernumerary for the first three to four weeks.

Managers supported staff to develop through yearly, constructive appraisals of their work.

The department was fully compliant with this process in April and May 2021. As of May 2021, 95% of staff had completed their yearly appraisal.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Part of the Professional Midwifery Advocates (PMA) role was to provide restorative clinical supervision, advocacy and to support quality improvement activities, education and leadership for midwives.

Mangers supported medical staff to develop through regular, constructive clinical supervision of their work.

The clinical director facilitated a consultant's forum and junior staff were allocated a consultant to act as their clinical supervisor.

The clinical educators supported the learning and development needs of staff.

The team produced training based on areas of identified risk such as themes from incidents. They team set up the MDT and weekly skills drills training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

We saw team meetings took place and minutes were available for staff to access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Training needs were identified by managers through one-to-one sessions with staff and through the PDR process. Training requests were escalated to the directorate and funded through training needs analysis or Health Education if funds were available. The head of midwifery said that no staff had been refused training requests in the previous two-year period.

We heard of good examples of continuing professional development. For example, the midwifery team on the day assessment unit had received ultrasound training. The continuing professional development process included a combination of peer review and training from the radiography department.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

For example, to support leaders within maternity develop their reflective skills, which allowed growth and development, a programme of coaching and mentoring was being provided. Initially 360-degree assessments for senior staff would allow feedback so that individuals can build upon strengths and address any areas for improvement. Recognising the requirement for effective teams would form part of the ongoing work which allowed for honest and timely conversations. Leaders had also commissioned with the Royal College of Midwifery insights programme, which is a series of workshops to support leadership which would be offered to all band 7 staff and above.

A senior midwife had developed a course with a local university for midwives to train and gain a qualification in the management of women who require high dependency care.

Managers identified poor staff performance promptly and supported staff to improve

We reviewed the human resources (HR) data relating to maternity services and found conduct cases were referred to HR. This meant managers followed processes to ensure they maintained high professional standards.

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 and effective multidisciplinary meetings to discuss patients and improve their care.

For example, a multidisciplinary team accessed expertise in managing the medical conditions during pregnancy. This meant advice was readily available when needed. This promoted planning of personalised, holistic care during labour and birth to help reduce the risk of adverse outcomes for the woman and her baby.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Maternity (inpatient services)

Dedicated speciality clinics were undertaken as a team/dual consultant approach. Named leads were specific to each clinic. Joint specialist clinics included renal, diabetes in pregnancy, obstetric neurology, obstetric haematology and perinatal mental health clinics. Additional dedicated specialist clinics/services ran in preterm labour, multiple pregnancy, infectious disease, substance abuse, vaginal birth after caesarean, maternal medicine, fetal growth, FGM, hypertension in pregnancy and obstetric anaesthetic

Staff referred women for mental health assessments when they showed signs of mental ill health, depression.

Community midwives completed a mental health assessment at patient's initial booking visit and midwives could complete a mental health assessment at any point during the pregnancy if they had concerns. The service had a dedicated mental health team to support patients where required. We saw there was a clear mental health referral pathway in place to support patients with mental health concerns during their pregnancy. This also included guidance regarding when to consider completing a cause for concern referral. The mental health midwife updated the patient's GP regarding the outcome of the mental health assessment on the same day as the appointment to ensure they were kept up to date. The mental health midwife requested staff inform them when one of their patients had given birth. If a patient was very distressed with mental health concerns during delivery, staff would contact the mental health midwife or the trust's Rapid Assessment, Interface and Discharge (RAID) team for additional mental health support. The mental health midwife supported patients with mental health concerns postnatally by calling patients or conducting home visits if required.

Is the service well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff were focused on the needs of women receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service 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.

Maternity (inpatient services)

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

However,

- Not all staff felt the senior leadership team were visible and approachable in the service for women and staff.
- Not all midwifery staff felt respected, supported and valued.
- Not all staff felt the service promoted equality and diversity in daily work and provided opportunities for career development.

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 supported staff to develop their skills and take on more senior roles.

The Supervisor of Midwives (SOM) role had been replaced with A-Equip or another model.

The service had Professional Midwifery Advocates (PMA). They were experienced midwives with additional training, to enable them to support the practice and professional development of midwives. PMAs supported and guided midwives so they could deliver consistent, high quality, safe maternity care.

The service demonstrated that the trust safety champions (obstetrician and midwife) were meeting bi-monthly with board level champions to escalate locally identified issues.

Meeting minutes showed regular items discussed included the number of deliveries per month, Caesarean section and induction rates and the number of stillbirths and neonatal deaths.

The service reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme.

The trust maternity services assessment and assurance tool reported all incidents had been reported. This included cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. Leaders discussed cases at the perinatal risk management group and reported to the trust wide learning from deaths group. The number of cases that were reported to the HSIB were included in corporate governance report.

The Head of Midwifery had access to the Trust Board and felt supported by the board.

The director of midwifery attended the board. The directorate leadership team said the service was supported by the board to ensure the maternity service was sustainable. For example, they supported initiatives to address the staffing challenges such as the uplift for community midwives. Board minutes reflected this. The director of midwifery attended both the Quality and Safety Committee and Trust Board and had been reporting monthly since January 2021, presenting the service's response plan to the Ockenden report (an independent review into maternity concerns at another NHS trust), refreshed maternity dashboards and a regular maternity update that reflects progress against their plan.

Maternity (inpatient services)

The management structure of the service.

There was a director of midwifery, a Senior Leadership Team (SLT) (general manager, head of midwifery, clinical director), five matrons (two community matrons, one inpatient, one risk and governance lead, one neonatal lead). The Director of Midwifery was responsible to the Group Director for Women and Child Health and accountable to Chief Nurse. The Director of Midwifery had as a seat at the board alongside the Chief Nurse as the expert in maternity care and service provision. The Head of Midwifery was responsible to the Directorate Clinical Director and accountable to the Director of Midwifery. The Consultant Midwife was responsible and accountable to the Head of Midwifery. Managers told us to meet the above fully, responsibility for Director of Midwifery would need to move to Chief Nurse and Head of Midwifery would be responsible to the Director of Midwifery.

Staff raised concerns about safe staffing levels in relation to a lack of leaders in some areas meaning they were not always able to deliver high quality compassionate care to women and their babies. For example, the risk team had not had a leader in post for over one year and staff said the HDU unit had no management. This meant staff had no leader to provide direction to the team, and therefore no clear expectations to help staff understand what they needed to deliver. Although staff were clearly motivated and passionate about patient safety, lack of support from management meant they felt undervalued and uncertain they were completing tasks correctly and effectively. Following the inspection the trust told us HDU had a lead midwife who worked both clinically and managerial and that the delivery suite manager also had oversight.

Staff had also raised concerns regarding staffing levels due to the impact of the requirement to now looking after transitional babies and their mothers. Staff had raised this with management who had set up meetings to discuss the staffing template of the transitional care service.

Governance meeting minutes and reviews.

We reviewed a sample of governance meeting minutes. All departments were represented including community, ante natal and serenity and labour ward staff.

Actions and learning points were disseminated throughout the service.

Actions points were shared with staff through a variety of channels such as a community newsletter, emails, daily huddles which were documented and saved to shared folders/drives, a professional update forum, a community quality and improvement half day (QIHD) and team meetings.

There were processes to enable staff to share good practice or report concerns up to the committee meetings for the service.

There were effective structures, processes and systems of accountability and all levels of governance and functioned effectively together and interacted each other appropriately.

The medical director was a designated board member to lead on safety for maternity services. The Chief nurse also led maternity services. This meant there were two named board members for maternity services plus a non executive

The senior leadership team said they had a strong voice at board level. The DOM was available and represented maternity at board level. They said the DOM was very good at providing feedback.

Maternity (inpatient services)

The Board routinely monitored quality and safety and took necessary action to improve quality and safety.

Key Performance indicators (KPIs) drove quality improvement through processes such as deep dives into potential areas of concern. All cases were reviewed to improve service delivery and performance, where lessons could be learnt. Improvement work had been done around perinatal mortality, with a reduction in term still births. Improved pathways for the deteriorating patient enhanced multidisciplinary training and live simulator training. Morning multidisciplinary audit of cases requiring surgical intervention in the previous 24 hours took place. All qualifying incidents were referred to HSIB and a quarterly report was shared to disseminate learning and appraisal of trust compliance and any immediate actions required.

Not all staff felt that they were able to approach the Head of Midwifery (HOM) and discuss any issues or concerns

Some staff told us the senior leadership team (SLT) did not foster positive relationships across the maternity service. Many staff said they did not know who they were.

Senior team and managers visibility and accessibly were variable. Senior staff had a good understanding of the day-to-day pressures and risk.

Although some staff felt the SLT did not understand the day-to-day pressures, we saw examples of understanding and action plans to address areas of concerns and risk. For example, following a listening into action session leaders reflected that the group were noticeably quiet. The leaders suggested that all future events required groups to have time to express views and openly discuss issues in the absence of senior staff/managers present. This was to enable free discussion. The trust had commissioned an external agency to assess the culture and a transformation programme was in place to address the staffing and associated risks and pressures in community midwifery. There was a clear disconnect between how the senior leadership team presented and how they were perceived by staff. The staff did not feel inspired, motivated or empowered. Although community staff said they were not informed by the SLT of what action plans were in place to address the staffing issues we saw examples of communication. For example, the senior leadership team wrote on the community midwifery newsletter “We are continually advertising on NHS jobs to fill the vacancies, and we will continue until we successfully appoint to all of these posts. The current advert closes on 14 April but will be reviewed weekly and shortlisted by the team leaders on a rolling basis. We have appointed a midwife to community and look forward to her joining us in June 2021”.

Community teams did not all feel part of the acute trust. Leaders were visible to the community staff and innovation encouraged.

Some community staff did not feel a part of the acute trust. Leaders had action plans in place to address this. For example, they had restructured the midwife study day so that inpatient and community midwives trained together. This would promote peer learning and break down barriers. Community matrons and staff could attend the weekly risk meetings virtually. The women and child health senior leadership team and executive board members had set up “Coffee and Chat” drop-in sessions. The matrons advertised this to community midwifes through their specialised newsletter. They wrote “We have managed to meet some of you, but we know there are lots more staff who we haven’t managed to see. We are based in the Matron’s office on the ground floor underneath the stairs to the parent education room. If you are passing, please knock on the door and say hello. Fiona will be at the (..) pub (AVFC) on 31st March between 11-1pm and (…) centre on 8th April between 11-1pm if anyone would like to drop in. We will let you know of future venues and times”. In another newsletter, leaders wrote “To help with recruitment and retention of staff in community, the Trust have agreed to a pay uplift of 5% for all band 5 and 6 Community midwives”.

Maternity (inpatient 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 vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a Non-Executive Director with responsibility for the Maternity Service.

They acted as a channel between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, Local Maternity System (LMS) leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges, and successes.

There was involvement of the midwifery and medical staff in innovation and change.

Leaders asked staff during a listening into action session on 25 March 2021 “What is your vision of our Maternity Service?” Staff contributed their views such as building a supportive environment within all levels (including the NNU). Staff were also asked to share what would help them achieve that vision and how this would be done. Staff shared views such as changes to layers of bureaucracy within the unit and defining roles and responsibilities at all levels.

Leaders worked to keep staff kept involved and motivated.

Quality improvement plan work progressed against the plan, including improvements in community midwifery, improved platforms for shared learning, a learning in action event was held on 25 March 2021 with over 60 attendees to co-design change and the external culture review has commenced.

Leaders had a vision for the services in the wider community.

The directorate level vision was ‘To deliver integrated care to support children, women & families to start well, grow well, live well and end well’

The vision and/or strategy linked to the local health economy.

The service formed part of the Black Country Local Maternity and Neonatal System (LMNS)

The vision and strategy linked to commissioning in the area.

For example, the Local Maternity and Neonatal System (LMNS) wide objectives were set against local KPI’s to improve outcomes and prevent health inequality. Service leaders worked collaboratively with trusts in the local region as part of the Black Country Local Maternity System (LMS) with the aim of improving maternity services for the local population in accordance with the Better Births guidance.

There was a clear vision and set of values specific to independent midwifery and maternity services, with quality and safety the top priority.

For example, the education and governance team produced an electronic central point of information that all staff could access. Included on this page, was up to date information on areas such as Maternity and Neonatal education, PROMPT, information on other training opportunities and risk updates lessons learnt from incidents and monthly audits, findings, recommendations and education

The service was part of a Maternity Voices Partnership for the local population to help shape maternity services that meet the needs of local women and families.

Independent services were working with providers and acute services to deliver a wider strategy to increase women's choice on birth.

The service was working with independent midwives who were helping with homebirths. The independent midwives also attended the Midwife Led Unit and acted as doulas for women. A *doula* is a trained companion.

Culture

Not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff did not feel the service promoted equality and diversity in daily work or provided opportunities for career development. The service did not have an open culture where patients, their families and staff could raise concerns without fear.

Some staff did not feel wanted and involved in the service development.

The service had several systems in place to involve staff in monitoring and reviewing safety. They had refreshed the monthly maternity safety meetings which were led by the Medical Director who also undertook safety walkabouts to ensure the staff voice was heard and to support shared learning. They had also recently appointed a non-executive director lead for these meetings. There were staff safety representatives from midwifery, risk and governance, obstetrics and neonates who liaised with all staff to ensure two-way communication and learning. A platform for sharing learning both internally and across the LMNS had been developed. A further piece of work was being led by the Deputy Director of Governance – Knowledge and Learning who would work with staff to agree the best approach for their learning to make a positive difference to patient care.

The Board promoted a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training.

The medical director who was the maternity safety champion promoted best practice and ensured safety and outcomes were regularly monitored. Staff did not feel the service had an open culture where they could raise concerns without fear. All staff we met during our inspection were welcoming, friendly and helpful. However, staff were very aware of the longstanding poor culture and staffing concerns. They expressed to us the impact the longstanding staffing issues, and poor culture had impacted on staff morale. Staff morale was very low. All staff we spoke with raised concerns regarding safe staffing and felt that their views and comments regarding this were not being considered. Staff reported continually escalating concerns relating to staffing levels with no response.

Some staff felt issues or concerns related to bullying and/or harassment within the service.

In the community service staff felt that some leaders were authoritarian in their approach. They also felt some leaders showed unfair preference regarding recruitment procedures and allocation of tasks. This included what was perceived as unfairly allocating more sought after shifts to certain staff.

The service had access to a freedom to speak up guardian.

Staff were aware of who the freedom to speak up guardian was and their role within the trust.

Staff knew how to raise concerns if they were unhappy about anything within the service but not all felt comfortable and able to use this system without fear of repercussions.

Although staff knew how to raise concerns, some staff felt there was 'no point' as 'nothing ever changed'.

The working relationship and culture like between community midwives, hospital midwives and doctors/ consultants were variable.

Although the relationship between midwives and medical staff were supportive, staff told us the senior leadership team (SLT) were not visible or approachable. The SLT had put processes in place to address these concerns. This included daily walkabouts from Head of Midwifery in addition working out of different venues to support the community Midwifery team. Staff forums were set up via video calls so they could speak to the Head of Midwifery. Most staff said the Clinical Director (CD) was approachable and supportive. However, some staff felt the CD had dismissed the recent public article in relation to the negative culture in the department. Staff therefore felt the CD had shown a shown a lack of acknowledgement and support for staff in relation to this issue.

The trust had also commissioned an external company to help create a culture of kindness within the directorate and organization. They wanted the band 7s to undertake bespoke leadership training through the Royal College of Midwives. They aimed to produce a culture of support and a feeling that staff are listened to and heard. They were also trying to increase the avenues by which staff could have their voices heard through the freedom to speak up guardians. They also want staff to feel appreciated because there have been lots of changes and they want staff to understand why the changes have been made. The directorate general manager said she did a weekly walkaround and she felt that more recently staff have been approaching her to talk about and raise concerns. There was also an occupational health department. During the Covid-19 pandemic, leaders developed a "wobble room" and a timeout pod if staff needed a time on their own. There was also the offsite staff well-being service named 'Sanctuary' which offered massages and aromatherapy for staff. Leaders also changed the staffing meetings so that all members would be able to be involved especially with issues related to such as sickness policies during the Covid-19 pandemic. As part of international midwifery day leaders thanked staff through the newsletter which read "We would like to take this opportunity to thank you all for your tireless efforts and determination over the last 12 months. Now is the time to reflect and look forward on our journey together to improve our services for our women, babies, families and teams."

Community staff did not all feel part of the overall maternity service.

Morale was very low across the community team. The SLT were aware of this and had action plans in place to address this. They had recruited two community matrons, and a Transformation Midwife post (for a fixed term period) to support the Community Midwifery Service to align processes and transform community midwifery services, by exploring new

ways of working and delivering a safe and effective service. In addition, the Community Midwifery team had been empowered to design a new way of working which then led on the "families" been developed. Leaders had commissioned an external facilitator who hosted a confidential one to one session open for all staff to attend as part of the transformation of the maternity service to support an improvement in the culture of the unit.

Staff were rewarded, for example submitted for local, regional or national award schemes.

The service celebrated staff through a variety of channels. For example, they produced and posted a video on a popular social media channel which captured the first-hand experiences of new mums in care of the staff and asked midwives why they loved their jobs. This was to celebrate international day of the midwives.

A newspaper article shared how West Bromwich football ground had been given over to postnatal care during the pandemic. All groups were instructed to induct their staff with MI awareness sessions, as well as Business Continuity awareness sessions.

Plans were in place for severe weather conditions.

The service had clear arrangements in place. For example, specialist transport could be provided in exceptional circumstances. Out of hours staff were required to contact the duty manager to discuss options for securing a taxi to come to work. All areas had business continuity plans agreed with their staff for cold weather, ice and snow.

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 trust had published and made public a bespoke Maternity Safety Improvement Plan.

The maternity safety plan had been reviewed more recently to ensure that it included all aspects of what had been captured from staff at all levels, women and families. The overarching plan was formulated of five individual action plans, including actions in response to Ockenden. On the 25 March the service held a learning into action event to share the findings of the local staff surveys, the schedule of work to support an improved safety culture and to co-design strategies to design a blueprint for real change. The event was attended by over 60 members of staff, including the support of the Chief Nurse. An independent review on the culture within the service was commissioned as part of the improvement plan. This will provide a current baseline to triangulate against a previous report from 2016 and the results of safety culture survey undertaken as part of the National Safety Collaborative in 2017/18. This was available on the trust's public board meeting minutes on the trust website.

The service submitted information to external stakeholders.

The service collected reliable data and analysed it. Data or notifications were submitted to external organisations as required. For example, 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.

Engagement

Maternity (inpatient services)

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.

Leaders used the friends and families responses to improve services.

For example, the maternity service, led by the ward managers implemented a local survey in January 2021 to ensure the woman's voice is heard and changes can be implemented to support improvement. The survey was introduced in November; the team are working to grow our response rates and continue to develop this further, with engagement both corporately and via the maternity voices partnership. Below is a selection of responses from the January survey. Results showed 60% of the respondents said the service was excellent, and 20% good and very good respectively. Fifty percent said they felt listened to well and very well respectively. All respondents said staff communicated in a way they understood. When asked how satisfied they were with the cleanliness and appearance of area, 29% said extremely, 64% said very well and 7% said somewhat. There was a purple phone where patients and family members could give feedback to the service. The maternity service also surveyed on elements of the service either AN, IP, PN through a text message. They also collect information through complaints.

The views of stakeholders were obtained.

The consultant midwife led on the maternity voice partnership (MVP) work stream. The trust's MVP was strengthened following the commissioning and tender lead by SWB CCG. Meetings took place four times a year. The head of midwifery maintained contact with the MVP CCG lead throughout Covid-19 and prior to first reformatted meeting structure. The Chair of the MVP was the user representative and lay person. The LMNS engagement work stream continued with input from service users to inform services.

The Maternity Transformation Programme sought to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver across 10 work streams. The programme was led by a Programme Board, supported by a representative group of stakeholders who scrutinised and challenge decisions made by the board.

The leadership took an inclusive approach to involving a range of equality groups.

The service had secured funding from the LMNS to support a pilot of a diversity and inclusion lead midwife for 12 months. The Equality and Inclusion lead would also assess the training needs of staff so that conversations around race and culture are sensitive and meet the needs of the communities' staff served. The lead will work alongside culturally diverse and vulnerable groups to dispel perceptions and provide assurance that safe, quality care will be provided in maternity services and ensure any barriers that prohibit women and their families accessing such care are removed. In this position a lead role will also be taken in relation to Equality, Diversity and Inclusion, developing an EDI framework and approach to support the Trust's commitment to foster an inclusive working environment that promotes equality of opportunity and diversity for all staff members, patients and their families. During the pandemic staff increased their support of at-risk pregnant women. For example, clinicians had a lower threshold to review, admit and consider multidisciplinary escalation for women from a BAME background, the service reached out and reassured pregnant BAME women with tailored communications. Staff recorded on the maternity information systems the ethnicity of every woman, as well as other risk factors, such as living in a deprived area (postcode), co-morbidities, BMI and aged 35 years or over, to identify those most at risk of poor outcomes.

Leaders had re-evaluated the risk assessment with community midwives. The saving babies lives lead midwife had worked with midwives to understands risks as they developed throughout pregnancy rather than at booking and at 36

weeks. An example of this was around the use of aspirin and making sure women were appropriately taking aspirin if it was required. All the clinics were open to bookings; a referral did not need to go through a consultant. There was a large portfolio of specialist clinics with clear criteria for referral. Women now came to two to three clinics rather than one clinic to ensure that women received the most relevant/expert care rather than a general clinic. The first clinic appointment took a full and holistic approach to ensure that the right care was put in place. There was a high-risk obstetric MDT meeting once a month, but leaders hoped that with the appointment of a high-risk lead, this would happen more frequently. At the time of the inspection the risk lead had left the organisation in March 2021. The trust had appointed a new risk lead in April 2021 and the post holder was due to start their role in July 2021.

The maternity portal, meant that patients could see all their risk assessments, scans and appointments. It was an app that patients could use to ensure that women were more engaged with their care. The online website was also available in 30 different languages and women could self-refer for medical assessment - called 'early bird'. There had also been work done in conjunction with the junior doctors to translate information leaflets for common procedures such as instrumentals, epidurals as well as developing videos in different languages. This was also very important for their Romanian population.

Through the Willow team, staff were able to provide continuity of carer services for BAME women. Unfortunately, this team was disbanded due to operational issues for example, a lot of these clinics happened in primary care settings which were turned into 'GP hot sites' which meant they were unable to be used for midwifery services. There were also problems in the team with staffing due to sickness and shielding. During the pandemic they noticed that lots of women weren't coming into hospital. The SLT asked the shielding staff to contact these women to educate them about reduced FM and encourage them to come to hospital if required. There was also a lot of messaging on the website and staff developed videos.

Maternity voices meetings were now taking place.

The links to the MVP were relatively new. The MVP had only had two meetings so far with the third one planned. The consultant midwife was heavily involved with them.

The service had examples of events to engage the staff in the service planning and any proposed changes to services. Managers held regular Listening into Action sessions. This was a systematic approach to engage and empower staff around any challenge. For example, the maternity team hosted a LIA on 25th March which was well attended. The event was hosted to help enhance the future development of the service, to ensure that staff wrapped care around their women, to give them the best, and safest birth experience possible. This forum allowed midwives to share ideas for improving and future proofing the service. You said, we did, involved informing the public about how their views and opinions had influenced change. For example, staff raised concerns about culture or attitudes from colleagues. Managers responded by stating "we have listened and therefore every "Tuesday positivity meeting" by way of engagement with all managers and are investing in all leaders through a leadership training package and coaching to support every Band 7. Following on from the trial SBL study day on 26/03/21, the team had very positive feedback and that staff felt it should be a rolling day that all staff should attend. From these leaders had introduced several future study days.

The service had examples of events to engage the public and staff in the service planning and any proposed changes to services.

The service was developing a virtual tour of the maternity department on the trust website. We saw staff involved in many videos on YouTube promoting their services and helping to recruit new members of staff. For example, a midwife showed parents-to-be around the new Induction Suite at City Hospital, where pregnant women would go if they need to be induced.

Managers were producing vision and strategy for the service and target areas for next three years. This had been circulated to staff.

Specific survey on communication and what good communication looks like to staff. Managers were working on a communication strategy. All preferred communication platforms were captured and managers reviewed these and put them in place. An audit trail was kept of these communication methods. The new communication strategy was shared with all staff

Learning, continuous improvement and innovation

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

The service had considered and acted on the MBRRACE annual and perinatal reports and other reports. The service had considered and acted on serious incident investigations and action plans and opportunities existed for learning from other trusts.

Prior to the pandemic a matrons' forum had been planned to enable learning between hospitals across the LMNS. Consultants from a neighbouring trust sat on the trusts PMRT board and vis versa. This enabled shared learning. Staff shared learning from Serious incidents through the monthly LMNS quality and safety meetings.

Staff were encouraged to develop the service and not just provide the service.

Since last summer there had been an improvement plan in place for maternity services. This had been reviewed more recently to ensure that it included all aspects of what had been captured from staff at all levels, women and families. It had been reviewed by both the Acting Chief Nurse and Medical Director before being submitted to the April Public Trust Board. There had been a delay in progressing the plan as quickly as the trust would have liked because of remarkably high community Covid-19 infection rates in the Black Country, however leaders felt it was now back on track and moving forwards.
Leaders commissioned an Insights Discovery Workshop called 'Understanding ourselves and others.' This was facilitated by the Royal College of Midwives. This included subjects such as Who am I? and Understanding how we see the world.' Staff were asked to fill out an online questionnaire. This was then turned into an insights discovery personal profile which was all about the individual staff member. It included areas such as strengths and weaknesses and management style. The profile was to help staff with a range of issues, change and growth. The Royal College of Midwives facilitated a workshop for staff called the foundation chapter. This was designed to encourage self-understanding, enabling the individual to develop effective strategies for interaction and better respond to the demands of their environment. The workshop included areas such as: Overview (personal style, interacting with others, decision-making), Key strengths and weaknesses and Value to the team.

Maternity (inpatient services)

Outstanding practice

We found the following outstanding practice:

- We saw an outstanding example of care for a woman to meet her choices through teamworking between the low-risk midwifery team and the obstetric team. This included a genuine involvement of the woman in the choices about her care in labour.

Areas for improvement

SHOULDS

- The trust should ensure that they continue to address their staffing needs. (Regulation 18)
- The trust should ensure they continue to address the low morale and negative culture in the service. (Regulation 17)
- The trust should ensure all staff complete their mandatory training.(Regulation 12)
- The trust should ensure all women are always provided with one-to-one care in labour. (Regulation 12)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and three other CQC inspectors and one special professional advisor. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.