Royal United Hospitals Bath NHS Foundation Trust

Chippenham Community Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Chippenham Community Hospital

Good

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Chippenham Birth Centre (Chippenham Community Hospital).

We inspected the maternity service at Chippenham Birth Centre as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level. We will publish a report of our overall findings when we have completed the national inspection programme.

Chippenham Birth Centre is located at a local community hospital, which is managed by another NHS provider and provides maternity services to the population of Chippenham, Frogwell, Pewsham, Corsham, Allington and the surrounding areas. Between March 2023 and October 2023, 46 babies were born at Chippenham Birth Centre.

The service had been closed for intrapartum care during the COVID-19 pandemic and had reopened for births in March 2023. It remained open during this time for antenatal care and clinics.

Maternity services at Chippenham Birth Centre include antenatal, intrapartum (care during labour and birth) and postnatal maternity care. The service has 6 clinic rooms, 3 delivery rooms with ensuite facilities and 2 delivery rooms with a birthing pool. Chippenham Birth Centre is opened daily from 8am to 8pm and opened as required during the night.

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

We had not previously inspected or rated maternity service at Chippenham Birth Centre as a standalone midwifery service. We rated safe as Good and Well-led as Good.

We also inspected 2 other maternity services run by Royal United Hospital Bath NHS Foundation Trust.

Our reports are here:

Frome Birth Centre – https://www.cqc.org.uk/location/RD121

Royal United Hospital Bath - https://www.cqc.org.uk/location/RD130

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited the birth centres and clinic rooms.

Our findings

We spoke with 3 student midwives, 5 midwives and support workers, 12 women and birthing people and their birthing partners and/or relatives. We received 5 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 9 patient care records, 9 'observation and escalation' charts and 9 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

Maternity

Good

We had not previously rated this service. We rated the service as good because:

- Staff worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- The service had enough midwifery staff.
- Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.
- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with Women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Although staff had training in key skills however not all midwives had completed the adult basic life support training.
- We found an out-of-date birthing pool evacuation standard operating procedure poster during inspection.

Is the service safe?

Good

We had not previously rated this service. We rated the service as good.

Mandatory training

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

Midwifery staff received and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Maternity

The service made sure that staff received multi-professional simulated obstetric emergency training (PrOMPT). Data showed as of 27 November 2023, 93% of midwives and 92% of maternity support workers across the trust had completed yearly PrOMPT training against a target of 90%.

In the same period, 95.4% of midwives had completed the fetal monitoring training and 94.1% had completed the maternity professional development day. Data showed that 83.2% of midwives and 80% of maternity support workers had completed the manual handling and pool evacuation training. Ninety-three percent of midwives and 92% of maternity support workers had completed the newborn basic life support training against the 90% target. Trust data showed that 31 band 6 and 7 midwives across the maternity services had completed the advanced newborn life support trainings. However, not all staff were up-to-date with their adult basic life support mandatory training. Records showed that 79% of midwives and 62% of maternity support workers had completed the adult BLS training against a trust target of 90%. Service leaders told us this was because updates had recently been changed from bi-annually to annually which had reduced compliance. Following the inspection, the trust submitted data which showed that 83% of maternity support worker and 66% of midwives had completed the training as of 4 February 2024. The service had a trajectory and a training plan in place to bring overall compliance within target.

In September 2023, the trust launched the 'Maternity Personalised Care and Support Planning training' and 'Maternity Anti-Racism Training'. Projections provided by the service showed that all midwives and maternity support workers would be compliant with both training sessions by February 2024.

Staff completed regular skills and drills training. For example, staff had recently completed home birth resuscitation, manual handling and pool evacuation skills and drills in the community in recent months.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency (a continuous electronic record of the baby's heart rate obtained through an ultrasound transduces placed on the woman or birthing person's abdomen), skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Staff also had several competencies they were required to complete such as intravenous (IV) medicines competency to ensure they were up to date with their clinical skills and knowledge.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Training records showed that 100% of maternity staff had completed Level 3 safeguarding adults training. Ninety-four percent of midwives and 88.1% of maternity support workers had completed the Level 3 safeguarding children and perinatal mental health training. Staff had access to regular safeguarding supervision.

Maternity

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team. Information about safeguarding concerns was identified as part of assessment and the ongoing management and support of individuals. Flags were attached to the electronic patient records, and a separate handover of safeguarding concerns were shared with staff at each shift change.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. The maternity specialist safeguarding midwives were part of the corporate safeguarding team.

The specialist safeguarding midwives worked closely with external agencies within the local Integrated Care Systems (ICS) to ensure the service fulfilled its statutory safeguarding requirements. This included attending various safeguarding meetings such as case conferences and pre-birth tracking meetings to discuss unborn babies with children's social care involvement.

The trust had a team of specialist midwives that were based within the service and who carried the caseload of women and birthing people with complex social factors such as drug or alcohol abuse, current or recent domestic violence and mental health needs.

Learning from safeguarding reviews, incidents, practice reviews and complaints was shared with staff via the newsletter and team meeting. Recent learning included themes around domestic abuse, risk assessments and infant crying.

Care records reviewed during inspection detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the unit and clinics.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward and clinic areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Maternity

The service generally performed well for cleanliness. From May to November 2023, the cleaning audit showed 99% compliance.

Fabric curtains were used around bed areas and were checked regularly for any signs of contamination and if noted were reported to housekeeping and changed. At 6-monthly intervals or sooner, if required, all curtains were changed. They were laundered on site. They had assessed the risk and deemed there was no greater risk in using fabric curtains. Staff told us new disposable curtains have been ordered by the community matron which were due to be delivered in the coming weeks.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. From August to November 2023, the hand hygiene audit showed 100% compliance.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the clinic areas and it was clear equipment was clean and ready for use.

Environment and equipment

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

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment were checked at every shift in the unit from September to November 2023.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. For example, women and birthing people had access to birthing pools, pool evacuation nets, birth balls and stools to support movement in labour. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, staff had enough home birth packs, a portable grab bag for emergencies and individual equipment needed for home visits. There was a ‘born before arrival’ equipment bag available for staff. Records showed all equipment and consumables were checked regularly.

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

There was a ligature risk assessment in place and completed in October 2023.

Assessing and responding to risk

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

Maternity

The Chippenham Birth Centre operated a low-risk maternity service and certain aspects of the maternity care pathway were not available on site. The service excluded induction of labour, caesarean section, or any major surgical procedure, inpatient care, transitional, and neonatal inpatient care. Staff risk assessed women and birthing people continually from the antenatal to postnatal period and there were clear criteria for use of the midwifery-led birth centre. Only women and birthing people who met the criteria for safe care used the service. The service also had clear criteria for use of the birth pool.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Maternity Early Warning Score (MEWS) for women and birthing people. We reviewed 9 MEWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed a quarterly audit of patient records to check they were fully completed and escalated appropriately. From April to July 2023, the service achieved 89.8% compliance against a target of 90%. The service also used a nationally recognised newborn early warning trigger and track (NEWTT) tool to identify babies at risk of deterioration and escalated them appropriately. From September to November 2023, the trust NEWTT audit result showed 99.7% compliance.

Staff completed risk assessments for each woman or birthing person antenatally and on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies' Lives version 3 care bundle.

The service had a clear escalation process for midwives to contact the consultants and labour ward coordinators at the main hospital site for any concerns. This included the use of the red phone line systems which connected the unit to the labour ward in the main hospital site.

The service had processes to transfer to the main hospital site if needed. If an obstetric review was needed for someone birthing at the unit, midwives made decisions to transfer with support from the labour ward lead midwife and the operational bleep holder at the main hospital maternity site.

The service had clear guidelines for when staff should transfer a woman to consultant led care from midwifery care. Staff understood this guideline and told us when they had used it to ensure the safety of women, birthing people, and their babies. Managers monitored the transfer of babies, women and birthing people to the consultant led care in the main hospital site. From November 2022 to October 2023, the average transfer rate from the service to the main hospital site was 22%. The top reasons for transfer were delay in progress and baby observation.

From July to November 2023, the average ambulance waiting time was 27 minutes from the service and 20 minutes from the women and birthing people home.

Staff knew about and dealt with any specific risk issues. Staff documented and reviewed care records from antenatal services for any individual risks to women, birthing people and babies such as gestational diabetes, long term conditions, safeguarding or mental health concerns.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The service had invested in the perinatal mental health service in recent years by expanding the team to include a psychological wellbeing midwife for birth trauma and a pregnancy loss support

midwife for pregnancy loss under 14 weeks. The team had also implemented a maternal wellbeing service. Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure paper and electronic care record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had regular safety huddles to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

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

The service provided a 7-day service for screening programmes such as antenatal screening, hearing, newborn and infant physical examination (NIPE) and the newborn blood-spot test. All women and birthing people who did not attend screening or antenatal appointments were contacted and followed up.

Women and birthing people who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with a consultant midwife and an obstetrician to discuss risks and options available to create a suitable birth plan together.

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

There was a lead midwife based in the service and a supernumerary shift coordinator or bleep holder on duty round the clock based at the Royal United Bath Hospital who had oversight of the staffing, acuity, and capacity on each shift including Chippenham Birth Centre.

The birth centre lead could adjust staffing levels daily according to the needs of women and birthing people. Births at the centre were staffed by the home birth team, community midwives and the community midwife on-call. The service was opened as required during the night and 2 community midwives covered the night on-call rota.

The service was staffed by 37 (23.42 whole time equivalent) Band 6 and 7 midwives, and maternity support workers. During inspection, there were 6 midwives, 1 band 7 lead midwife, 2 maternity support workers, which met the expected staffing levels.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and birthing people accessing the service.

Maternity

Leaders calculated and reviewed the number and grade of midwives and midwifery assistants needed for each shift in accordance with national guidance. Leaders collected trust-wide data on staffing across all sites to complete a maternity safe staffing workforce review using a recognised national tool in 2022 and the final report was received in April 2023. This review showed a shortfall of 11.93 whole time equivalent (WTE) staff for the current funded establishment.

From May to July 2023, the trust reported an unfilled shift rate of 10% for the midwives and 30% for the maternity support workers for the maternity services. Staff we spoke to during inspection told us there were no gaps in staffing in the service, but 1 to 2 staff could be redeployed to the labour ward in the main hospital site when there was high acuity.

The service had reducing vacancy rates and low turnover rates, sickness rates and use of regular bank staff. The trust had a recruitment and retention strategy in place. Over the past 12 months, the trust had an active recruitment campaign, which had resulted in the recruitment of six internationally educated midwives and 2 nurses undertaking the nurse-to-midwife master's conversion course. Leaders told us that the success of the retention team had supported 100% retention of the newly qualified midwives who commenced in August 2022. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Data supplied by the trust, showed appraisals completed for maternity staff was 82% against the trust target of 90% as of October 2023. Managers made sure staff received any specialist training for their role.

The education and retention team supported midwives. The maternity service had a large education and retention team which included lead midwives for recruitment and retention, quality improvement and education for staff and for students, clinical skills facilitator, lead international midwife and lead fetal monitoring midwife. The maternity quality improvement and education lead midwife worked cross sites. Staff and students spoke highly of the team and felt well supported.

Records

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

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 9 paper records and found records were clear, complete and detailed. Staff recorded advice given to women and birthing people including discussion around risks. There was evidence on completion of several risk assessments and stickers were used to indicate when these assessments had been completed by the multidisciplinary team. For example, we saw stickers in the paper records of when SBAR, NEWTT, sepsis screening, and pelvic health services assessments and/or referrals had been completed by staff.

The 2023/2024 trust documentation audit showed that the service achieved an overall 81% compliance on the standards audited which were applicable to the midwifery led units. This was below the trust target of 90%.

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

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

Maternity

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each woman and birthing person's medicines regularly and provided advice to them and their carers about their medicines.

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

Staff stored and managed all medicines safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff had access to medicines used to respond to emergencies safely. For example, midwives had access to a post-partum haemorrhage emergency response trolley.

Midwives had training in post-natal contraception and could prescribe contraception through patient group directives (a legal framework that allows some registered healthcare professionals to supply or administer medicines to a pre-defined group of patients without seeing a doctor or a nurse prescriber).

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on paper notes for the 9 sets of records we looked at were fully completed, accurate and up-to-date.

The target for medicines management training compliance was 90%. Compliance rates in November 2023 were 97.1% for midwives working at the birth centre.

Staff learned from safety alerts and incidents to improve practice.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 27 incidents reported in the 3 months before inspection and found them to be reported correctly.

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

Maternity

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers investigated incidents thoroughly. Managers and senior leaders reviewed incidents potentially related to health inequalities. Managers and the patient safety midwife shared learning with their staff about never events or serious incidents that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. Managers debriefed and supported staff after any serious incident. Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

Staff understood the duty of candour. They were open and transparent and gave Women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Learning from incidents were cascaded to staff in various ways such as weekly newsletters, safety boards, posters, emails and a cloud-based team channel.

Is the service well-led?

Good

We had not rated this service before. We rated well-led as good.

Leadership

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

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

Maternity services at Chippenham Birth Centre were managed as part of the Family and Specialist Services Division at Royal United Hospitals Bath NHS Foundation Trust. The service was managed by a Band 7 lead midwife who was supported by the community matron for the trust. The community matron reported to the Deputy Director of Midwifery for the trust. The divisional maternity service leads included the divisional director, director of midwifery and divisional director of operations. They were supported by specialist managers and specialist midwives.

Staff told us the service and trust leadership structure had been further strengthened in recent years by the appointment of a community matron and divisional director of midwifery.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. The community matron visited the community team weekly. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible

and encouraging they were. Staff spoke highly of the lead midwife, community matron and the director of midwifery, and felt supported by them. Staff said the new community matron and director of midwifery were a 'breath of fresh air, caring, approachable and visible'. Staff told us they could go to any of the leadership team and trust executive, and they would listen, which made them feel valued.

The service was supported by maternity safety champions and non-executive directors, who had clinical backgrounds and invested in the improvement of the service. The chief nurse was the executive maternity safety champion for the service and upon taking this role, she had spent some time in the service and the infection control team to better understand it. She held regular listening events for staff and walk arounds to learn more about the service, the pressures faced and how this linked to national maternity recommendations and audits. Staff felt the service had stronger links and visibility at trust board meetings, which was due to the strong leadership and maternity safety champions team.

Leaders supported staff to develop their skills, take on more senior roles and take part in leadership and development programmes to help career progression. The senior leaders, including the safety champions, participated in the perinatal culture and leadership programme designed for the maternity services. The Band 7 midwife had completed a leadership course. All midwives in the service were assigned different roles and a rotation program was in place to shadow the Band 7 clinical lead to help develop leadership skills. This involved the rotation of the Band 7 midwives in the community and acute settings to various clinical areas to observe and understand the different pressure each area faced and recognise the importance of each other's role. This was in line with the trust values and behaviours to improve care, efficiency and communication.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The strategy also focused on personalised care, health inequalities, workforce training, international recruitment and digital transformation.

The trust was looking at the sustainable long-term vision of the on-call rota for the community birth team as the number of births in the birth center had reduced. Senior leaders were carrying out on-going engagement events with staff to get feedback and map out future plans for sustainability.

The service recognised maternity workforce retention was key to delivering the vision and goals. It had presented a maternity and obstetrics workforce report requesting for ongoing investment in the service to meet increasing demands on maternity services across the trust. There was a retention and recruitment strategy in place with a clear focus on staff wellbeing. For example, the service had employed a Band 7 recruitment and retention lead, there was a rolling Band 5

and Band 6 job advert, and the service increased the number of professional midwifery advocates to better support staff. There was also a new mental health and well-being leaflet for new starters introducing an inclusion team and an inclusion specialist midwife. The service had also started to roll out inclusion and diversity training for all staff, improved preceptorship and induction for new midwives, as well as pathways into midwifery for maternity support workers.

Leaders and staff understood and knew how to apply the vision and strategy and monitor progress.

Culture

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

Staff felt respected, supported and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed people's care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Staff we spoke with were proud to work at the service and reported being happy in their work. Close team working, great ethos, feeling valued, safe culture and strive for improvement were said to be a positive factor of working at the trust. Staff reported enjoying coming to work and felt listened to. Staff were extremely proud of the care provided and particularly of how women and birthing people received compassionate care and that they did not feel the impact when the service was busy.

Staff spoke positively about the safety culture, collaborative working, and a no blame culture following serious or adverse incidents. The service had systems in place to support staff following serious or adverse incidents. This includes hot debrief, professional midwifery advocate support, staff listening and psychological counselling service, and trauma risk management (TRiM) service.

Some staff had been working at the trust for several years and told us there was equal opportunity to progress in their career. We saw examples of staff who had progressed to a leadership role over the years from junior staff, student midwives, and support workers.

Student midwives told us the service had a good culture and positive learning environment. There was a sense of community between staff, they felt involved and received adequate support.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. The service had introduced inclusion week and rolled out cultural competency and anti-racism training to improve health inequalities. Eight midwives, 1 neonatal nurse and 1 maternity support worker had also been enrolled on the black maternity matters training in June 2023. Staff told us they had been

encouraged to take additional training such as training on trans-pregnancy. Staff said that it helped them to understand the issues around inclusion and health inequalities and provide better care. To further strengthen diversity, inclusion and health equality, the inclusion lead had started a book club for staff and books written by people from different ethnic or sexual orientation background were shared.

The service had launched a 'milk project' in 2022 which provided infant feeding support in identified areas of deprivation, and a translation application which had both received positive feedback from staff and service users.

The trust had a maternity transformation and health inequalities lead that monitored data around health inequalities. Data was reported monthly to the trust board integrated performance committee meeting using a specific dashboard and was shared monthly on health inequality presentation slides. The health inequalities lead linked in with the quality improvement and patient safety team and held regular meetings.

The service had identified higher 'did not attend' (DNA) rates and late booking among ethnic minority groups and was undertaking a 'deep dive' audit and liaising with the primary care service on how to address the issue and improve outcomes.

The service provided QR codes with information on antenatal care, induction of labour and postnatal care which were available in 10 different languages.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in visitor areas. Staff also gave women, birthing people and their families a feedback card which was used to identify any negative feedback or complaint. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints, identified themes and shared feedback with staff; learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. Maternity services trust-wide received no formal complaints between August and October 2023.

There has been engagement directly with local people from ethnic minority groups to devise an improvement plan they will benefit from.

Governance

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

Maternity

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

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

Staff followed policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. However, we found an out-of-date version of the birthing pool evacuation standard operating procedure (SOP) poster during the inspection. This was escalated to the lead midwife, who removed this immediately and reassured us there was an updated poster. We noted that the up-to-date birthing pool evacuation SOP was displayed before we left the unit.

The service held various governance meetings which fed into the trust board meeting. This includes the operational meetings, community team catch up meetings, neonatal and maternity meetings, safety champions meetings and speciality meetings. Governance meeting agendas included discussion around all aspects of governance and oversight of the service such as incidents investigation, complaint themes, clinical dashboard themes, workforce, education, training, audit, health inequalities, priorities, reports that needed to be signed off and shared with trust board.

The trust had introduced a monthly maternity and neonatal specific divisional performance review meetings to help leaders have a deeper oversight and governance on the maternity services. The trust maternity services governance was further strengthened by regular local maternity and neonatal system andlocal maternity and neonatal inisght visits. Senior staff told us the governance process in the service had been further strengthened in the last 2 years by the appointment of the community matrons, expansion of business support team, robust quality improvement and patient safety team and how information were shared at the trust board. The safety champions received monthly report about the maternity service and were involved in the review and discussion on the learning from incidents. In 2022, the chief nurse commissioned a transformation team to complete a deep dive in the maternity service and also engaged with other chief nurse colleagues to further understand the pressures in the maternity service and drive improvement.

The service had recently appointed an inclusion midwife and a performance audit co-ordinator to support the service's health inequalities agenda, to review data and break down statistics by ethnicity.

The trust quality improvement and patient safety team included a lead midwife, quality improvement education midwife, retention lead midwife, 3 clinical skills facilitators, administrator, quality and patient safety investigator, quality audit midwife, 2 patient safety midwives, and 2 governance coordinators.

A clear audit plan for 2023 – 2024 was in place and included audits which were national audit drivers for example, Saving Babies' Lives, Ockenden, and Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE). MBRRACE was a national collaborative programme of work into maternal, stillbirth and neonatal deaths. For example, the audit plan included use of the National Perinatal Mortality review tool and identification and recording of risk status for fetal growth restriction.

Management of risk, issues, and performance

Maternity

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

The trust completed a Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 4 declaration of compliance to the board of directors in January 2023. The report identified that the service had achieved all 10 safety actions as part of CNST.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. Top risks across maternity services were electronic patient records, the community on-call rota, staffing, and ultrasound capacity for sonographers. The leadership team took action to make change where risks were identified.

Senior managers reviewed incidents and clinical outcomes such as third degree tears, post partum haemorrhage specific to the service at the trust maternity governance meetings. The service had process and guidelines in place for the management and transfer of maternity obstetric haemorrhage.

All Maternity and Newborn Safety investigations programme (MNSI) cases were investigated internally by the trust as well as independently by the MNSI. Serious incidents and MNSI cases went through specific incident criteria process. This was to ensure there were no immediate actions needed to be taken.

There were plans to cope with unexpected events and the service had a detailed local business continuity plan.

The maternity service had achieved the UNICEF baby-friendly initiative (BFI) silver status and was working towards achieving the gold status. The BFI is an initiative that supports breastfeeding and positive parent infant relationships by working with public services to improve standards of care.

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 service collected reliable data and analysed it. They had a live performance dashboard which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

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**.** The service had a digital midwife to support staff accessing electronic information systems. The digital midwife role was to provide digital tools to make processes smooth and safer. For example, the digital midwife regularly updated the information on the cloud-based team channel and had developed a specialist midwife directory online to support ease of communication.

The service reviewed data to focus on reducing health inequalities using quality improvement methods.

Data or notifications were consistently submitted to external organisations as required. Leaders submitted data sets to the perinatal mortality review tool (PMRT), maternity dashboard, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries), Care Quality Commission and CNST.

Women and birthing people had access to resources on the trust website, regional maternity and neonatal voices partnership website and the regional local maternity and neonatal system website. Information on the websites included various topics such as virtual tours, pregnancy, labour and birth, baby loss, and maternity and neonatal voices partnership. Staff told us that women and birthing people also had access to a joint regional maternity personalised care mobile application which provides information needed throughout pregnancy.

Engagement

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

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP was working with the trust on co-production to improve services and met with representatives from the trust and service users regularly to progress this work.

Leaders understood the needs of the local population. The service welcomed feedback from women, birthing people, and families. People could feedback to the service through surveys, complaints and through the local MNVP. In the last 12 months, the maternity services had included 2 patient stories in the trust board meetings and feedback had been used to drive improvement in the service. This included a training video for staff around breastfeeding. The trust maternity services had upgraded chairs for recliners following the MNVP feedback to senior leaders.

The MNVP held regular listening events, drop-in sessions at clinics, attended governance meetings, and participated in 15-steps and engagement with community groups including hard to reach communities and people living in areas of deprivation. The MNVP attended some of the clinics and engaged with women and birthing people with long term conditions, people from ethnic minority groups and those from lower socio-economic backgrounds. The MNVP had also been involved in review of policies and engaged with midwives, women and birthing people in the relaunch of the community and home birth teams.

Maternity

The trust maternity service had taken part in the National Maternity 2022 NHS Staff Survey. The result showed that the maternity services performed higher than trust average on 5 out of the 9 standards audited and similar to trust average on 1 standard. The trust maternity services scored below or slightly below trust average on 3 standards audited. This included morale, staff feeling 'safe and healthy', and working flexibly. The result showed there was an improvement from the 2021 result on all standards audited.

In the 2022 CQC Maternity survey, the trust scored the same as other trusts for 43 questions, however better and somewhat better than the national average for 8 questions.

The service always made available interpreting services for women and birthing people and collected data on ethnicity.

The service also celebrated and engaged staff through staff meetings, handovers, newsletters, quality board, message of the month, surveys, team brief folder and improvement boards. The service had made changes to the service provision by operating an open on demand service at night which was been staffed by on-call teams. The service had carried out a staff survey and several listening events to engage with staff during the change in management around the on-call rota, long-term vision and explored staff's preferred on-call options of covering the service at night.

We received 5 responses to our give feedback on care posters which were in place during the inspection. The responses were positive, and themes included good antenatal care, breastfeeding and tongue tie support, communication and felt listened to.

We spoke to 12 women, birthing people and their partners during the inspection. All feedback received was highly positive and women and birthing people told us that staff were skilled, knowledgeable and had behaved in a caring and professional manner. The women and birthing people felt listened to, happy with the breastfeeding support and knew the names of their midwives and other staff that had cared for them. They had received positive care in person and over the phone throughout pregnancy. Staff were reassuring and took their time to answer questions and the environment was clean, safe and relaxing.

Learning, continuous improvement and innovation

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

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement and education lead who championed and co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. For example, the trust wide maternity diabetes team had worked collaboratively to implement a gestational diabetes digital app for women to equip them to manage their diabetes. The trust provided mobile phones for women and birthing people that were unable to have one in order to access the diabetes digital app.

Maternity

To further improve the trust third- and fourth-degree tear rate, the trust had set up a pelvic floor physiotherapist service to work with midwives to deliver care to women and birthing people during the antenatal period. The trust continued to work towards understanding the reason for the increase in the rates of third- and fourth-degree tears.

A community home birth team had been rolled out as part of a quality improvement project.

The Milk Project was piloted by maternity and neonatal services within the local maternity and neonatal system (LMNS). The aim of the pilot was to reduce health inequalities. Pregnant women and birthing people within specific local areas were offered additional support in pregnancy around infant feeding to help reach their feeding goals.

The trust had developed a maternity and neonatal communication plan to improve staff engagement. The plan aimed to provide 8 steps to better engagement. This included talking, welcoming and supporting staff, hosting maternal and neonatal forums, walk and talk sessions, opportunities for feedback, shared learning, time to meet senior leaders and regular staffing updates.

Outstanding practice

We found the following areas of outstanding practice:

- The trust maternity services recognised and understood the local demographic and the additional challenges families using the service faced. Particularly around health inequalities, complexities and co-morbidities. The service had implemented several initiatives to tackle health inequalities, which included the 'Milk Project', gestational diabetes app, and various staff training.
- There was a strong focus on engagement with staff, women and birthing people, maternity and neonatal voices partnership and local maternity and neonatal services in the region to drive improvement and provide safe and compassionate care in the service.

Areas for improvement

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

Action the trust SHOULD take to improve:

Chippenham Birth Centre (Chippenham Community Hospital)

- The service should ensure staff were up to date with the adult basic life support training modules.
- The service should improve staff compliance in the documentation audit.
- The service should continue to address the vacancy rates in the service and ensure there are enough staff on each shift.

Our inspection team

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