The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Russells Hall Hospital

Requires Improvement

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Russells Hall.

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

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

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

We did not review the rating of the location therefore our rating of this hospital stayed the same

Russells Hall is rated Requires improvement.

How we carried out the inspection

We spoke with 30 staff including senior leaders, matrons, midwives, obstetric staff, specialist midwives, clinical governance leads and safety champions to better understand what it was like working for the service. We interviewed leaders to gain insight into the trust's leadership model and the governance of the service. We reviewed 8 sets of maternity and 10 medicine records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recent reported incidents as well as audits and audit actions.

We ran a poster campaign during our inspection and asked the trust to contact women and birthing people who had used the service to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received over 500 feedback forms from women. We analysed the results to identify themes and trends.

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

Maternity

Good

Our rating of this service improved. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service 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.
- Staff were proud of the organisation as a place to work, spoke highly of the culture, and were clear about their roles and accountabilities. They focused on the needs of women, provided personalised care and were proactive in addressing health inequalities.
- The environment was clean, well maintained and additional equipment had been funded to ensure staff had the equipment needed to support women and birthing people.

However:

- The service did not always have enough midwifery and obstetric staff. This impacted the calls received on the triage phone line, the one to one care on labour suite and postnatal care.

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Nursing and midwifery staff received and kept up-to-date with their mandatory training. The trust's own target for staff to complete mandatory training was 90%. In most areas this had been achieved. Where staff compliance was below 90%, they were close to achieving their target. For example, compliance rates for moving and handling were 88%. Moving and handling training ensured staff were able to support a woman or birthing person in a pool evacuation emergency. Birthing pools were available in the maternity led birthing centre and the delivery suite.

Compliance rates for mandatory training had improved since the last inspection in July 2019.

The service made sure that staff received multi-professional simulated obstetric emergency training.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, 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.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were rostered on to their mandatory training days. However, we were told there had been occasions when staff had been removed from training to cover the unit. Practice development midwives told us how their team had grown to now include 3 clinical skills midwives, as trust leaders had recognised the need to ensure staff received quality up to date training.

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 followed the baby abduction policy. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. A test of the baby tagging system and a baby abduction drill was completed annually. The last drill highlighted concerns regarding fire doors unlocking when the fire alarm sounds. These concerns led to a security maternity working group to address the issue with an action plan to strengthen security further.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff were 86% compliant with 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.

The trust had leads for safeguarding adults and children. These leads worked across the trust supporting both nursing and midwifery teams. There was a specialist team for vulnerable women, which included a substance misuse midwife, vulnerable women's midwife and an equality diversity and inclusion midwife.

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 and received training in the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics. For example, staff had ensured women and birthing people with neuro disabilities had altered birth plans to support their individual needs, that were created with the support of the woman birthing person and families. We were also told about an occasion where a British sign language interpreter was organised to support a woman for the whole of their labour.

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. However, on reviewing care records midwifery staff had not always documented or been able to ask this question. An audit of records showed leaders were aware and had raised the importance of enquiring about the home situation of families in the most recent Maternity In the Know newsletter staff newsletter.

Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Maternity

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

Staff followed safe procedures for children visiting the ward.

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.

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 and environmental audits were completed every month in all maternity areas. Hand hygiene audits showed ward areas to be meeting the 95% compliance target. Action plans were created following environmental audits with actions for the cleaning and estates teams.

The premises were all visibly clean and cleaning records were up to date. We saw cleaners going about their duties throughout the day. There were suitable furnishings which were clean. Staff used green I am clean stickers to show that equipment and furnishings had been cleaned after use. Environmental audits showed staff knew what to look for when assessing the environment. Audits had actions on of which was to remind staff to report damaged furnishings.

The flooring and decoration in clinical areas allowed for effective cleaning and was well maintained.

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

The service had access to cleaning staff 24 hours a day, out of working hours the service was able to call on trust wide cleaning staff.

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 service was a spread over 2 floors, with the outpatient and clinic facilities being on the ground floor and inpatient facilities on the 2nd floor. The delivery suite, maternity led unit (MLU), triage, maternity theatres and ward areas were only accessible by locked double doors that were manned by security staff.

Maternity

Triage was opened 24 hours a day with a dedicated phone line. There were assessment rooms as well as a designated waiting room. Triage was for women from 20 weeks of pregnancy up to 6 weeks postnatal who were experiencing any problems related to pregnancy or following birth. Women also attended for early labour assessments. Fetal assessments were offered for reduced fetal movements. Triage was close to labour ward so women could be transferred immediately if needed.

There were 2 theatres located on the 2nd floor past triage. One theatre was allocated to emergency caesarean sections whilst the other was allocated to elective caesarean sections. There was a large recovery 2 bedded bay. We were informed that there is access to a further theatre is needed within the general theatres of the hospital.

Maternity ward was located past triage and theatres. The ward supported post and antenatal women and birthing people. The ward was made up of side rooms and 3 bays and 4 rooms for transitional care babies and mums.

Delivery suite consisted of a bereavement room, 8 birthing rooms, 1 of which was equipped with a birthing pool, 2 enhanced care rooms and 6 beds dedicated for the use of induction of labour. The bereavement room was sound proofed and had been decorated with families in mind. All rooms had ensuite facilities and were well equipped to meet the needs of women and birthing people.

The MLU was adjacent to the delivery suite. MLU supports women and birthing people who have been assessed to meet the criteria for a low-risk birth supported by midwives. There were 3 ensuite birthing rooms, 1 with a fixed birthing pool and 1 with an inflatable birthing pool, as well as a 2 bedded postnatal area.

The ground floor area of the maternity department consisted of the day assessment unit and antenatal clinics.

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 outside maternity theatres was checked daily.

The service had suitable facilities to meet the needs of women and birthing people's families. 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, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. The service had bariatric equipment ready in case it was needed.

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.

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

We reviewed 8 maternity care records. In each record risk factors had been defined and identified at the booking appointment and risk assessments were completed at each maternity contact. This enabled women to be allocated to the correct pathway to ensure the correct team were involved in leading and planning their care.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. Staff completed and recorded MEOWS observations electronically. Management audited compliance in line with deteriorating patient pathway (DPP). These audits identified areas for improvement. For example, not all observations were being completed within recognised time frames. The audit identified where learning needed to be addressed with time scales for this to be completed in prior to the next planned audit.

Following a quality improvement project, in October staff reintroduced a standardised risk assessment tool for maternity triage. The effectiveness in which the service had implemented the assessment tool meant the overall compliance for triaging women and birthing people within 15 minutes of arrival had increased from 67% to 89%. Leaders had also introduced further training within the Triage department to ensure the service maintain compliance and were aiming to consistently achieve over 90% of women and birthing people being seen within 15 minutes of arrival. Audits showed 85% of women who were assessed to be needing to be seen by obstetricians were seen with in the time frames relating to their assessed need. Actions from the audit was for the trust to continue to monitor and audit the assessment tool, as well as appointing a member of staff to support the team with the integration and embedding of the assessment tool in maternity triage.

Staff told us that it was not always possible for the triage phone line to be manned by a fully qualified midwife and that there were times when maternity support workers (MSW's) had answered calls, gained the callers contact details for the midwife to return the call as soon as possible. On the day of the inspection there was not a designated midwife roster to answer the calls. This meant the midwife who was assessing women and birthing people on their arrival was also taking the calls.

Leaders said there was midwife cover for telephone triage for 5 days a week between the hours of 09.00 and 21.30. An audit of calls had shown this to be the time for maximum call volume.

Following successful recruitment drive they will be able to cover 7 days a week. We observed during the inspection that calls from other departments were put through to triage out of office hours. We also observed that women and birthing people used the line to contact other areas within the maternity department. Staff felt this was because women and birthing people knew the phone would be answered whereas women and birthing people had already had difficulty in getting through to other areas of the department. These additional calls placed extra pressure on the midwives within triage as well as there being a risk that women would not get through to talk to a midwife in a timely manner.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communications and teamwork. The service audited WHO checklists. Data from January, February and March 2023 showed the service was 100% compliant with the tool.

Staff knew about and dealt with any specific risk issues. For example, staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). However, data we reviewed showed compliance of fresh eyes in September 2022 as 32% and in October 30%. Following theses audits the trust put an action plan in place. They shared the outcome of the audits with all staff via the Maternity In the Know newsletter and safety huddles, as well as having weekly CTG meetings. As a consequence, an improvement in compliance between November 2022 to January 2023 with the compliance consistently above 68%.

Maternity

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

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 electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and 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.

During the inspection we observed that there was a huddle attended by all staff at the beginning of the day, in the centre of the unit, followed by individual handovers in each ward areas. We were told by staff that there was only one medical handover at 08.30 in the morning and that work was on going to improve this to make 2 medical handovers. After the inspection we asked for clarity about handovers and were told the service had 2 medical handovers and 2 ward rounds every day.

Staff had 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.

The service provided transitional care for babies who required additional care.

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

Midwifery Staffing

The service did not always have enough maternity staff. Staff had the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. During the time period of 1 October to 26 April the trust had reported 94 red flag incidents. There were 4 occasions where it had been identified that women were at risk of not receiving 1.1 care. However, the service was able to provide 1.1 care by following their escalation policy. There were 2 occasions where the community on call midwife was called in to support 1 occasion where the baby was delivered in triage receiving 1.1 care from the triage midwife and 1 occasion where active labour had not been recognised. This has led to a referral to the Healthcare Safety Branch (HSIB) The service had 100% compliance with shift leader being supernumerary.

Staff gave us mixed feedback regarding staffing levels, some said staffing levels had improved over the last 12 months and that this had been achieved by employing newly qualified midwives from 2 local universities and recruitment of 24 international midwives. However, others told us that several midwives had been promoted internally to specialist midwife roles, and these midwives had not been replaced.

Midwives in their preceptorship were supported well. They were given a named buddy and supernumerary shifts for 4 weeks.

We were also informed that supporting supernumerary staff such as students and international midwives that were working towards registration with their professional body was putting pressure on the staff team. We were told that there had been occasions where there were more supernumerary staff on a shift than there were qualified midwives to support them. The practice development nurse agreed this had been an issue and when informed they had taken the international midwives off shift to do training, easing the pressure on the staff team.

Students and international midwives we spoke with said they felt supported by the staff team.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service completed a maternity safe staffing workforce review in line with national guidance in May 2023.

At the time of the inspection the service had a vacancy of 10.3 whole time equivalent (WTE) midwives across the service as well as maternity leaver rate of 12.5%.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas staff rotated between the delivery suite and the maternity ward which meant they had the skills to work in both areas. Staff said they often felt they were needed to support on the delivery suite which could leave the maternity ward short of staff.

Feedback we received from women and birthing people was that the maternity ward was often understaffed, and that women, babies and birthing people often had to wait for care and pain relief.

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, 81% of midwives had received an appraisal for the year 2022/2023 by March 2023.

Medical staffing

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

There were 4 vacant posts within the medical team during the inspection. However, 4 posts had been filled but were waiting for agreed start dates.

Gaps in rosters were covered by locums as well as current post holders working additional hours.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

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

The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

We received mixed feedback from medical staff we spoke with regarding being allocated time to complete training. We were told the rota manager was not always responsive to training needs.

All medical staff we spoke with said they enjoyed working at the service and that leaders and senior medical staff were supportive and approachable.

Healthcare Safety Investigation Branch (HSIB) had found that a senior locum obstetrician had not been provided with access to the trust’s IT system. Following recommendations from HSIB the trust had ensured there was an induction process for all new staff have access/login to IT systems prior to commencing their first clinical shift.

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 an electronic record’s recording system. The system used was a trust wide system and not maternity specific. This made it easier for staff to view they women and birthing people’s full medical records. We reviewed 8 patient records and found they were clear and complete.

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.

The service audited the quality of patient records monthly and communicated the results of the audits to all staff. Where a need had been identified for individual staff members digital support was organised.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 electronic prescription charts and found staff had correctly completed them.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

The pharmacist had identified an issue with Thrombo-Embolus Deterrent (TED) stockings (a compression stocking used to prevent deep vein thrombosis after surgery) not always being documented as prescribed when there had been an assessed need and was addressing this with relevant staff at next teaching session.

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

Staff stored and managed all medicines and prescribing documents safely. 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 take action if there was variation. Senior staff audited the monitoring of medicines.

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 a digital system, the 10 sets of records we looked at were fully completed, accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed safety incidents well. Staff recognised but did always report incidents and near misses due to time constraints. 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.

Leaders could not be assured they had full oversight of all risks within the service due to inconsistent reporting. 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. However, some staff said that they did not always have time to complete an electronic incident report. Staff also said they were not always happy with feedback received following submitting an electronic incident report. For example, a staff member said when they had reported a woman or birthing person had waited longer to see a clinician that was assessed to be appropriate the response following the electronic incident report had been that all appropriate action had been taken.

The service had no 'never' events on any wards.

Maternity

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

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers and the clinical governance team were aware of the criteria for reporting incidents to the Healthcare Safety investigation Branch (HSIB) for investigation and that any still birth or neonatal death required a 72 hour review. The trust had referred 6 incidents to HSIB in the last 6 months; they had received 2 reports and were waiting for the other 4 to be published. Recommendations had been made by HSIB regarding ensuring placentas were sent for pathological examination in line with national guidance and ensuring junior obstetric staff were supported. The trust shared action plans following these recommendations.

There were 34 incidents open over 60 days. However, the majority of the incidents had a completed investigations and either were waiting for a review by HSIB and neonatal review or had open actions preventing the incident from being closed.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. Managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service had several ways in which they shared learning from incidents with staff such as extra ordinary newsletters, weekly newsletters, maternity governance newsletters as well as during safety huddles.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

Is the service well-led?

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

Leadership

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

There was a clearly defined management and leadership structure in place. The Head of midwifery (HOM) was supported by the Directorate manager, Clinical Director, Maternity matron, and 3 deputy matrons. There was joint working between leaders within maternity, the rest of the trust, and external agencies and bodies to maximise care provision for women and babies.

Maternity

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. Governance meeting minutes showed leaders had reviewed staff surveys and staff engagement sessions and were prioritising actions to improve staff experience.

There was a local maternity and neonatal systems Dashboard where information was shared with other local maternity services who were then able to offer support at times of high acuity.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. 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.

The service was supported by maternity safety champions and non-executive directors. Safety champions reviewed incidents as well as doing regular walk rounds of the service to observe and offer support to staff.

Staff were supported to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes and quality improvement projects to help all staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a joint strategy with nursing 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 joint strategy with nursing 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.

The nursing and midwifery strategy had 6 objectives looking to achieve, strong leadership, developing the workforce, delivering the fundamentals of care, learning for improvement, patient safety and sustainable growth.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. The trust had action plans in place following recommendations and insight visit.

Leaders and staff understood and knew how to apply them 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. We spoke with a wide range of staff grades and disciplines. Staff said the staff team was like a family and they were proud to be part of the team.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' 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.

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. The trust had appointed an equality diversity and inclusion midwife who was working with community groups to engage with women and birthing people from all ethnic minorities in the area, as well as women and birthing people from a deprived background and the deaf community.

The equality and diversity midwife, substance misuse midwife and vulnerable women's midwife worked together to support women and birthing people with a range of needs using an umbrella term of social complexities.

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. Staff said that it helped them understand the issues and provide better care.

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.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. For example, there had been feedback received regarding women and birthing peoples experience of induction of labour, how they were not always kept informed and there were often delays. This had led to an improvement project including women and birthing people, Maternity Voices Partnership (MVP) and staff. Since the improvement work had been implemented there had been a decrease in the time women and birthing people were waiting. Time from admission to commencing induction of labour had gone from 7 hours 33 minutes down to 1 hour and 48 minutes.

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.

Of the policies reviewed during our inspection the majority were up to date. There were 2 policies going through the governance and assurance meeting on the day of the inspection and another policy that had received an extension to its review date by the Chief nurse.

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.

Management of risk, issues and performance

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

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. The service also ensured to audit areas of the service following incidents, or patterns of incidents at the request of the Maternity governance group. 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.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

Staff contributed to decision-making to help avoid financial pressures compromising the quality 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**.** There was a live dashboard of performance 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**.**

Data or notifications were consistently submitted to external organisations as required.

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services.

The service asked women and birthing people for feedback on the service and analysing auditing and actioning responses.

Women and birthing people were asked to tell their stories of using the service at recent improvement events.

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

The service used QR codes around the department to share information. The information can be translated. The service provides women and birthing people with technology to access this should women and birthing people not have their own.

The trust had tried to appoint staff that reflect the local community including maternity support worker who is bilingual and able to talk to some non-English speaking women and birthing people in their own language.

Leaders understood the needs of the local population.

Staff told us they felt leaders listened to them when they gave feedback. For example, staff had feedback that they wasted time looking for blood pressure (BP) machines. The trust funded wall mounted BP machine in each room including on delivery suite. Computers on wheels with large screens had been provided and multiple power points around the room so staff were always able to face women and birthing people when writing up notes.

Learning, continuous improvement and innovation

Maternity

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.

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. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

In March 2022 the trust responded to poor staff survey and a high number of incidents and complaints within the Maternity service. Leading to an impatient improvement project and an outpatient improvement project.

The aim of the inpatient improvement project was to reduce the number of hours that the Maternity ward was closed, as this had an impact on patient and staff experience.

Staff, women and birthing people were encouraged to take part in the improvement events looking at improvements in induction of labour, elective caesarean sections, and triage.

Improvement boards were visible on the deliver suite and maternity board giving staff opportunities to suggest improvements.

Outstanding practice

We found the following outstanding practice:

The trust had identified needs within the community in need of additional support. The Vulnerable women's midwife, Substance misuse midwife and Equality diversity and inclusion midwife supported women and birthing people with a range of social complexities. They ensured women and birthing people they were supporting had individualised plans of care. Ensured interpreting services including British Sign Language were available during labour. As well as working with community groups to offer support and advise.

Areas for improvement

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

Action the service SHOULD take to improve:

Russells Hall

- The service should ensure sufficient staff to cover all areas of the maternity department including for answering the triage phone line, one to one care on labour suite and postnatal care.
- The trust should continue to monitor and improve on the compliance of CTG and fresh eyes documented by staff.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors. An obstetrician Specialist adviser and 2 midwife specialist advisers. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care