Milton Keynes University Hospital NHS Foundation Trust

Milton Keynes Hospital

Inspection report

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Date of inspection visit: 08 & 09 March 2023
Date of publication: 05/07/2023

Ratings

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

Our findings

Overall summary of services at Milton Keynes Hospital

Good ➔➔

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 Milton Keynes University Hospital.

Milton Keynes University Hospital NHS Foundation Trust provides a full antenatal, intrapartum, and postnatal maternity service to a population of approximately 320,000 people living in Milton Keynes. From April 2021 to March 2022, there were 3,725 deliveries at the trust.

We last carried out a comprehensive inspection of the maternity service in May 2019 when the service was rated good for safe, effective, caring, responsive and well-led. The service was judged to be good overall.

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

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

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

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

- Our ratings of the Maternity service did not change the ratings for the hospital overall. We rated maternity safety as good and well-led as outstanding. The overall hospital rating remains as good.

Our reports are here:

Milton Keynes University Hospital– https://www.cqc.org.uk/location/RD816

How we carried out the inspection

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

Maternity

Good ➔➔

Our rating of this service stayed the same. 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. The service managed safety incidents well and learned lessons from them.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- 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 promoted equality and diversity in daily work, and provided opportunities for career development.
- 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. People could access the service when they needed it and did not have to wait too long for treatment.
- The leadership drove continuous improvement and staff were accountable for delivering change. All staff were committed to continually learning and improving services.

However:

- The bereavement room did not fully comply with national guidance. The planned new facility may not be ready for 2 years.
- A new incident reporting system was not fully utilised by all staff and there was a risk of under reporting as a result.

Is the service safe?

Good ➔➔

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Ninety-six per cent of staff had completed all the mandatory training courses against a trust target of 90%.

Maternity

The service made sure that staff received multi-professional simulated obstetric emergency training. Nighty-four per cent of staff had completed their practical obstetric multi professional training (PROMPT) against a trust target of 90%. Data showed that 99.6% of staff had completed their medicine and medicine competency training. Staff spoke positively about the PROMPT training and how it included learning from real life cases and videos from the ambulance service.

The mandatory training was comprehensive and met the needs of women, 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. Training data showed that 96% of staff had completed their CTG training. In addition to the mandatory CTG training, regular external CTG masterclasses were offered to the multi-disciplinary teams (MDT) staff.

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. Staff were given protected time to complete mandatory training and attend skills and drills both in the hospital and community. Also, all community midwives had attended an external emergency training in the community.

Mandatory training included maternity specific human factors training for all MDT staff. Staff spoke positively about the maternity specific training, skills and drills and human factor faculty training and how it includes learning from incidents and complaints. Staff had completed skills and drills on pool evacuation, maternal collapse and post-partum haemorrhage in the last 12 months.

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. Ninety-seven per cent of staff had completed their level 3 safeguarding children training. This was an improvement from the last inspection.

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.

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. Women and birthing people records detailed where safeguarding concerns had been escalated in line with local procedures. Where there were safeguarding concerns, a safeguarding flag was put on women and babies electronic records.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the last 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. There were systems to ensure the deep cleaning and decontamination of rooms following a discharge or transfer. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The cleaning supervisors carried out weekly cleaning inspection walkaround of the maternity wards to ensure high cleaning standards were maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control (IPC) and hand hygiene audits. Data showed hand hygiene and IPC audits were completed every month in all maternity areas. From December 2022 to March 2023, staff achieved 100% compliance on the hand hygiene audit and 93% in the IPC audit. The service achieved an overall 95.4% compliance in the March 2023 hand washing facilities audit.

We observed that the labour ward regularly achieved a 5-star cleaning rating within the last 12 months, which was displayed in the maternity area. From 28 November 2022 to 6 March 2023, the service achieved 99.3% compliance in the national standards of healthcare cleanliness audit against a 98% target.

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

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, women, birthing people and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas.

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. However, the bereavement room was not soundproof and did not fully comply with national guidance.

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

The service carried out regular risk assessments including an environment ligature and self-harm risk assessment of the maternity areas.

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 reviewed during inspection showed that emergency equipment were checked daily by staff.

Staff regularly checked birthing pool cleanliness and the service had a contract for testing for Legionnaires' disease.

The service had enough suitable equipment such as portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment to help them to safely care for women and birthing people and babies.

There were suitable facilities to enable the birth partners to attend and support women and birthing people.

The service had enough suitable equipment to help safely care for women and birthing people and babies. For example, in the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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 mortuary unit on the labour ward for the safe keeping of a deceased baby whilst the parent was still admitted on the ward.

The service had a designated room used for counselling women and breaking of bad news in the maternity clinic; the room was adequately furnished. The service also had a relative's room and a patio on the labour ward for where women and birthing partners could relax and have a break when needed.

The service had a furnished bereavement room to care for bereaved mothers and their families. The room was located in a quieter area of the ward but was not soundproof in line with national guidance. This meant that bereaved mothers could hear the sound of other babies crying on the ward. Senior managers and specialist midwives told us the service had engaged with bereaved families to get their feedback to improve the service. The service had not received any complaint about the bereavement room location and the room not being soundproof. However, senior managers told us that some feedback from women have highlighted that they had found hearing the cry of babies have helped their bereavement recovery process.

The hospital had plans in place to build a new maternity building which include a dedicated maternity theatre, recovery areas and bereavement suite. Managers told us they had funding for the new build and work was due to commence in 2024/2025.

Assessing and responding to patient risk

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

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 Modified Early Obstetric Warning Score (MEOWS) for each women and Newborn Early Warning Trigger and Track (NEWTT) for each baby. We reviewed 6 MEOWS and 5 NEWTT

records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed a quarterly audit of MEOWS and NEWTT records to check they were fully completed and escalated appropriately. In the last 3 months, staff achieved a 93% compliance in the MEOWS audit and 90% compliance for the NEWTT audit. This was against the trust target of 90%.

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.

The service had appropriate midwifery staffing in place to manage the maternity telephone triage. There was a designated midwife on each shift allocated to respond to and manage the triage telephone line.

Staff completed risk assessments for each woman on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. The maternity triage waiting times for the period of 14 November 2022 to 13 December 2022 showed staff reviewed 87% of women and birthing people within 15 minutes of arrival. The top reason for women attendance to triage related to reduced fetal movement (33%), abdominal pain (17%), women in early labour (15%), spontaneous rupture of fetal membranes (9%) and antenatal bleeding (7%).

Staff knew about and dealt with any specific risk issues. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The 2022/2023 quarter 2 audit showed clear interpretation and management plans following CTG in 95% of cases and staff did ‘fresh eyes’ at each hourly assessment in 76% of cases. There was action plan in place to increase staff compliance on the hourly assessment. The service carried out a re-audit in quarter 3 which showed a 6% increase in staff compliance on the fresh eyes hourly assessment.

From October to December 2022, the service carried a SBAR (Situation, Background, Assessment, Recommendation) audit, which showed an overall 97.1% compliance. SBAR is a communication technique that provides a framework for communicating information about women and birthing people condition between health professionals.

The fetal growth restriction audit for the period of January to August 2022 showed that 100% of women had a risk assessment at booking and follow-up anomaly scan in line with the saving babies lives care bundle. Women (95%) with high BMI were offered growth ultrasounds assessment from 32 weeks.

From December 2022 to January 2023, staff achieved 90% compliance in the World Health Organisation (WHO) surgical checklist audit. Data also showed that staff achieved between 99% to 100% compliance in the swab and instrument access audit in the last 3 months.

Women were offered screening for infectious diseases, such as hepatitis B and syphilis. Women were also offered influenza (flu) and pertussis (whooping cough) vaccination in pregnancy, which was in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, updated January 2017). The antenatal handheld records we reviewed confirmed this.

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.

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

Staff shared key information to keep women and birthing people safe when handing over their care to others. The women and birthing people care record was on a secure electronic patient record system used by all staff involved in the women'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. Staff had daily safety huddles to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about the women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for women and birthing people.

Women who required one to one care following delivery were cared for on the labour ward to manage risk for a short period of time before being transferred to the postnatal wards.

The service ran regular specialised clinic to support women identified with risks to ensure women and birthing people safety and improved outcomes. This included mental health clinics, diabetic clinics, pelvic floor service and pre-term birth services. The service also held weekly MDT meetings to discuss high risk obstetric anaesthetic cases.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment on each shift. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers (MSWs) needed for each shift in accordance with national guidance. They completed a midwifery safe staffing workforce review in 2021 in line with national guidance. This review recommended 1:24 midwife to birth ratio and 160 WTE whole-time equivalent (WTE) midwives and maternity support workers Band 3 to 7 compared to the funded staffing of 147.2 WTE due to the increase in complexity of women seen in the service. The maternity service had a shortfall of 22 WTE staff. The midwife to birth ratio had fluctuated between 1:28 to 1:36 from January 2022 to January 2023 due to staffing and birth rate. To ensure safe staffing and safety of women in the service, the decision was made to suspend the continuity of care service.

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. From December 2022 to February 2023, the service reported 12 (2.7%) red flag status incidents. Senior staff told us there had been an improvement on their RAG rated status in recent months. In the last 12 months, the service was mainly rated as green (80%) and amber (19%). From December 2022 and February 2023, the service reported an overall 92.3% staff fill rate.

There were two midwifery shift co-ordinators on duty around the clock, one of which was supernumerary who had oversight of the staffing, acuity, and capacity. A maternity manager was on call 24 hours a day, 7 days a week, to ensure the department is safely staffed. The service also had a maternity bleep holder on weekdays to support the maternity service when there was increased activity due to planned elective procedures.

Staffing was monitored by senior managers daily at the daily maternity situation report meetings. Managers accurately calculated and reviewed the number and grade of midwives and MSWs needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance.

The ward manager adjusted 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 and acuity. During inspection we noted that the number of midwives and healthcare assistants matched the planned numbers.

The service had reducing leaver rates and turnover rates and use of regular bank staff. At the time of our inspection, the vacancy rate was 15% (22 WTE) for midwifery staff.

The staff turnover rate was 19%, which was mainly related to staff that had received promotion and progressed to other roles within the maternity service. The maternity leavers rate for staff that had left the trust was 3.6% in the last 12 months.

The service had a recruitment and retention plan and had recently recruited midwives to start in April and May 2023.

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 sickness rate for nursing and midwifery staff in the division decreased from 11.2% in March 2022 to 5.8% in May 2022, before increasing to 7.4% in September 2022. This sickness rate was higher than the trust target of 3%.

The sickness rate for midwifery staff had remained consistently above 4% in the last 12 months. The overall sickness rate for midwives in the last 6 months was 4.8% and 9.4% for the maternity support workers. Sickness rate peaked in December 2022 and mainly associated with increase in cold and flu.

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. Hospital data showed that 93% of staff had received an appraisal against the 90% trust target. We noted that 100% of consultants had completed their appraisal. A practice development team supported midwives.

Managers made sure staff received any specialist training for their role. For example, some midwives had completed or received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

Maternity

For the period of December 2022 to February 2023, 99.7% of women received one to one care during active labour against the trust target of 100%.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low turnover and sickness rates for medical staff. The service had low vacancy rate for medical staff. At the time of inspection, the service had only 1 vacancy for a registrar which had been filled and the staff was going through pre-employment checks.

Consultants were on site weekdays from 8am to 9pm and on-call 9pm to 8am. Consultants were on site on weekends 8am to 1pm and 7.30pm to 9pm. They were on call during weekends from 1pm to 7.30pm and 9pm to 8am. The service always had a consultant on call during evenings and weekends. The intensive care unit consultants were also available to support the maternity service for any emergencies that may occur at night.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Managers could access locum doctors when they needed additional medical staff. Staff told us they rarely used locums as they were adequately staffed. Managers made sure locum doctors had a full induction to the service before they started work.

The service had low rates of bank and locum staff. 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. Staff told us they rarely used locums and used their own bank pool of staff to cover any gaps in the rota.

The service had expanded the number of consultants by recruiting 4 additional consultants in recent years. The service had also recruited 4 new middle grade specialty and associate specialist (SAS) doctors since March 2022.

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. The service had a new consultant development programme to support newly recruited or promoted consultants.

Data supplied by the trust showed there were 13 (12.1 WTE) consultant obstetricians, 35 anaesthetists, 17 (16 WTE) registrars and 11 (11 WTE) senior house officers (SHO) working in the maternity unit at the time of this inspection.

The anaesthetic rota was compliant with ACSA standard 1.7.2.1 and the maternity service had a dedicated anaesthetist 24 hours a day, 7 days a week to cover labour ward. The service held weekly anaesthetic clinic and was planning to increase the frequency of the clinic due to increase in anaesthetic demand.

The service had 2 dedicated SHOs and 2 registrars covering the maternity and gynaecology service with the support of a consultant between 8am and 8.30pm. The service had 2 resident registrars and 1 resident SHO on site at night 7 days a week.

Medical staff told us that the medical roster was well organised. They had the same team of medical staff working Mondays to Thursdays which provided continuity of care and team members. Staff confirmed this created a good learning environment as the same team worked together for 4 days and nights. Junior doctors felt it was easy to escalate concerns and ask for help from consultants as they were on site until 9pm, they knew the acuity in the unit and any clinical issues to occur.

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 6 paper records and found records were clear and complete.

Handheld notes were documented and given to women and birthing people. They carried their own handheld pregnancy records, which staff completed and advised them to bring at each antenatal appointment and, on any occasion, when they attended the hospital. This was in line with the NICE Antenatal care for uncomplicated pregnancies guideline (2019).

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 documentation audit for the period of October to December 2022 showed an overall 78% compliance on the 12 standards audited. Staff performed well in the risk assessments, VTE and safeguarding assessments at booking, infant feeding and informed consent standards. Areas for improvement in the audit was around documentation at follow-up antenatal appointment, admission and post birth.

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 electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 5 prescription charts and found staff had correctly completed them.

Staff reviewed each woman'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.

Staff completed medicines records accurately and kept them 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 actions to take if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or when they moved between services. Medicines recorded on the digital systems for the 5 sets of records we looked at were fully completed, accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

We observed midwives using a red apron system during drug rounds to alert staff, women and birthing people to the fact that they are administering medicines. This ensured staff were not interrupted or disturbed during drug rounds and to prevent medicines incident, which was in line with best practice.

Incidents

The service managed safety incidents well. 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. Although staff recognised and reported incidents and near misses however there have been a reduction in the number of reported incidents due to a change of the reporting system.

Staff knew what incidents to report and how to report them. However, there had been a 38% reduction in the number of reported incidents in recent months due to a change on the incidents reporting system. The impact of the change of system was in the service risk register and senior managers had oversight on the issue and had mitigation actions in place to address this such as twice daily safety huddles for escalation. We saw evidence that staff had been supported with training videos and drop-in support sessions to improve their confidence and competency in using the system. Managers had worked collaboratively with the incident reporting software provider and their external regulator to address some of the issues staff were facing when using the new system. This had resulted in some improvement and the hospital data showed there had been 60% increase in the number of reported incidents in January 2023.

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 12 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no ‘never’ events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. Staff involved women and their families in the investigations of serious incidents. In all serious incident 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 a maternity governance team who were responsible for sharing learning from incidents with staff.

Maternity

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

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation regarding 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.

Staff received feedback from investigation of incidents and thematic reviews, both internal and external to the service. For example, staff discussed shared learning from a serious incident at a maternity governance meeting in January 2023. Leaders reminded staff of the importance of early recognition of sepsis and recognition and escalation of an abnormal CTG.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident. Managers debriefed and supported staff after any serious incident.

The service had a trauma risk management (TRiM) system in place to support individuals in the immediate days and weeks after an incident event perceived as traumatic. The service had a faculty of MDT TRiM practitioners and managers who facilitated the assessments and support for staff. Staff spoke positively about the TRiM support they had received from their colleagues.

Is the service well-led?

Outstanding ☆ ↑

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

Leadership

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

Leaders had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

There was a clearly defined management and leadership structure. The maternity leadership team consisted of a divisional chief midwife, associate directorate of operations, divisional director and clinical director. The maternity leadership team were supported daily by matrons, consultant midwives, deputy head of midwifery, governance lead and specialist midwives.

Maternity

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. Staff felt there have been improvement in the service due to change in the service leadership team.

The service was supported by maternity safety champions and non-executive directors. Staff told us the maternity safety champions regularly carried out a walkaround of the maternity service.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. For examples some midwives have completed master's programme in advanced clinical practice (ACP) and aspiring NHS leadership courses.

The service leaders told us they had good direct access to the trust board, and this worked very well. We saw from the minutes of board meetings that the trust board had oversight of the maternity service performance and received presentations regularly on the service progress to national maternity safety recommendations. The service was supported by maternity safety champions and non-executive directors.

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. The 2021-2023 strategy was focused on leadership, models of delivering care, lifelong learning, technology, innovation and research, professionalism, inclusivity and civility. The maternity vision focused on tackling inequalities, service improvement, partnership with the Maternity Voice's Partnership, MDT training, leadership and culture.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and planned to revise the maternity 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.

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.

Maternity

There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place to work and speak highly of the culture. 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. The 2021 staff survey result highlighted that the trust was higher than average compared to comparable trusts. They were best in their region and nationally for 'staff engagement' and 'we are always learning' standards. The trust had the highest score in 'autonomy and control', 'appraisals', 'motivation' and 'involvement'.

Staff spoke positively about the safety culture, collaborative working and supportive relationship between MDT teams. There were opportunities to learn together, staff felt respected and there was no hierarchy among MDT staff. Staff told us there was equal opportunity to progress in their career.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed women and birthing people 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. 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. Staff we spoke to have not experienced bullying or harassment from their managers or colleagues. The service had an equality and diversity group and culture task and finish groups and a shared decision making council to support staff. The service was carrying out a culture survey and at the time of the inspection had received 147 responses from staff. The service aimed at using the feedback from the survey to drive improvement for staff and birthing women.

Multi-disciplinary teams (MDT) staff had been supported to attend an external 2-day cultural safety and competency workshop. The workshop provided participants with the tools to self-reflect and understand their own values and attitudes towards race, migration, health inequalities and diversity.

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 women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

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 and governance meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Maternity

The service celebrated staff and team success and supported good staff practice through a thank you initiative system, staff awards and appreciation cards.

The service launched a QR code system to promote a safety culture and the well-being of women and staff. Staff and women could use the graphic on the QR code to share 'how was your day today?' and request if they needed support, raise concerns or speak to someone. Staff spoke positively about this initiative and how it had helped them to raise any concerns they had or access the right support.

The service supported staff and their well-being through various medium such as access to occupational health, lead professional midwifery advocate, health and wellbeing midwife, preceptor and retention midwives, MDT workplace behaviour champions and staff wellbeing checks at the beginning of shifts.

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.

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 staff through sub-committees and staff meetings.

Staff followed up-to-date policies to plan and deliver high quality care in line with evidence-based practice and national guidance. The maternity policies, guidelines and information leaflets were available on the trust maternity session on the trust website to ensure information was made accessible for women, birthing people, staff and public. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up-to-date.

Multidisciplinary staff at all grades including junior and middle grade doctors were involved in audits and attend governance meetings.

Staff spoke positively about their governance process and told us there was an "effective governance processes that involved active discussion with staff rather than statement writing".

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings and reports. The governance meetings included service, divisional and trust board meetings such as maternity assurance group meeting and Clinical Negligence Scheme for Trusts (CNST) meeting.

The practice development team produced a quarterly newsletter in a video format, which contained series of photos and short video clips demonstrating the different learning and training with a voice over. Staff spoke positively about the newsletter and how relatable it was to things they have been involved in. The video's had included topics like; PROMPT and pre hospital training with ambulance service.

Maternity

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 in the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) 2022 audit, NHS Staff Survey 2022 and General Medical Council National Training Survey (GMC NTS) 2022. Managers and staff used the results to improve women and birthing people's outcomes.

The maternity dashboard showed that the service was meeting the target on breastfeeding initiation rates, 3rd and 4th degree tear, still birth and premature birth rate. We noted that the trust had the lowest premature birth rate and still births within their region. However, the service was not meeting their target on the smoking cessation rates at booking and delivery in hospital compared to other trusts in the region and nationally. The service had actions in place to address this. A health promotion midwife had been recruited, which was funded by the LMNS and a smoking cessation support worker was funded by Public Health England to carry out home visit and community activities to support women to help reduce the number of women smoking at booking and delivery. The service worked closely with the local and regional councils around smoking cessation with the aim to drive improvement for women and improve women and birthing people outcome. The service was not meeting their KPI on the number of major obstetric haemorrhage above 1500mls by 1.4%. Managers were carrying out a deep dive to look at any themes and trends from data, including ethnicity to drive improvement and improve outcomes.

Managers and staff carried out a comprehensive programme of regular audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified issues and took action to make changes. Managers shared and made sure staff understood information from the audits. We observed that local and national audit data were displayed across the maternity areas for staff, women and visitors to access.

There was a proactive approach to anticipating and managing risks to people who used the service. 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 acted to make changes where risks were identified.

The maternity service had a risk register which included risks such as staffing, incident reporting and fetal fibronectin test (a test used to rule out preterm labour). The risk register also included a risk category, status and description of the risk, severity and rating of the risk. The risk register contained control measures in place, assurance actions to mitigate risks, any progress made and the risk approval status.

There were plans in place to cope with unexpected events. The service had a detailed local business continuity plan.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

Maternity

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 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, which enabled them to understand performance, make decisions and improvements.

Women, birthing people, staff and public had easy access to information needed about their pregnancy, condition and delivery. The service had 60 information leaflets on the maternity website and the website could be translated to any language. Women, staff and public could also access 105 service maternity specific policies and guidelines on the website. The service had also created a maternity glossary of terms for women and several maternity areas tour videos which was available on their website for women to access.

The information systems were integrated and secure**.** Data or notifications were consistently submitted to external organisations as required.

The service was working to develop an app which will allow women to have access to their electronic care records.

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. Innovative approaches were used to gather feedback from service-users, including people in different equality groups, and there was a demonstrated commitment to acting on feedback.

Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about women and birthing people care. The MVP were passionate about their role, engagement with the service and difference they made to women and birthing partner who accessed the service. The MVP had regular meetings with the trust and easy access to the senior leadership team to escalate any concerns promptly. They attended regular training in the hospital such as cultural competency training to help them carry out their roles effectively. The MVP held bi-monthly listening events at lunch and evening time to receive feedback about service and refurbishment ideas for the service.

The MVP were in the process of launching a random active kindness campaign from April 2023 which will involve women and birthing people giving feedback about the MDT staff and positive experience in the service. The feedback will be displayed across the service and a thank you gift pack will also be given to staff to celebrate their act of kindness and promote positive behaviour.

The trust valued their partnership working with the MVP and engaged with them regularly to ensure they were involved in service planning and delivery. This included walk arounds, review of policies and complaints response, co-production of information leaflets, website development and quality improvement projects. The MVP had also been involved in the review and approval of the antenatal classes education lesson plan to ensure it met the needs of the population.

Maternity

A systematic approach was taken to working with other organisations to improve care outcomes and tackle health inequalities. The service engaged well with other NHS providers within their region. The local maternity network (LMNS) held regular serious incidents panels where investigation and findings from respective trusts were discussed and peer reviewed. Staff told us this promoted shared deep dives into areas for improvement and support changes within the network.

Leaders understood the needs of the local population. The service engaged with the community including women and staff from different religious, ethnic and minority backgrounds to ensure their views and experiences were gathered to improve on the service delivery. There was a strong focus on reaching the hard to reach communities. The fetal medicine lead was upskilling and supporting the GPs and ethnic communities to care for antenatal women with long-term and/or complex medical condition in the community. This was part of a community project that focused on tackling health inequalities and pre-conceptual care around diabetes, maternal health and wellbeing. The fetal medicine lead worked with midwives and some specialist to upskilling GPs around illness and long-term conditions that may impacts on maternal health in pregnancy.

Local and senior managers were visible on the wards, they had walk arounds, which provided women, birthing people and staff with the opportunity to express their views and opinions The service held regular 'meet the team events' which was also attended by the MVPs. This gave people who were due to give birth the opportunity to come and speak to the MDT staff such as specialist midwives, anaesthetists, medical staff and consultant midwives. The service also engaged with women, birthing people and their families through various medium such as weekly birth reflections, forget me not groups and barbecue events for bereaved families. The forget me not group was created to support families that have had a loss through miscarriage, termination of pregnancy, stillbirth or a neonatal death.

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

Managers engaged with staff through various staff meetings, forums, listening events and newsletters.

The service engaged with key organisations including other NHS trusts and local authorities and charities to improve on women and birthing people outcomes.

In the 2022 CQC Maternity Survey, the trust performed better or somewhat better than expected on 5 standards, about the same on 38 standards and performed worse or somewhat worse than expected on 8 standards when compared with most other trusts.

We received over 240 feedbacks from women and birthing people during this inspection period. Most of the feedback was a combination of positive and negative feedback. Themes from the positive feedbacks included compassionate care and service received, supportive staff and staff professionalism. Themes from the negative feedbacks included communication, staff attitude, pain management and staffing levels.

During inspection, we spoke to 2 women and they spoke highly of the MDT staff and the care received. They felt valued and staff had listened to them and treated them as individual.

Learning, continuous improvement and innovation

Maternity

The leadership drove continuous improvement and staff were accountable for delivering change. 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 continuously learn, deliver change and improve 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. Safe innovation was celebrated. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

The lead risk midwife won the NHS England excellence and innovation award following the presentation of the newly developed maternity bleep holder game at the Oxford patient safety shared learning event. The game was developed in the maternity service to encourage staff to consider the different human factors that weave through the variety of activity and communication that occurs daily within the service.

The specialist bereavement midwife was shortlisted for the Royal College of Midwifery award in the bereavement category for outstanding contribution to the midwifery services around pregnancy loss and bereavement care.

The specialist bereavement midwife created a bereavement garden in the hospital grounds for bereaved parents of babies and children with the support of 8 bereaved parents.

The specialist data, digital and inequalities midwife was awarded with a Chief Midwifery Officer Silver award for her role in the digital transformation within maternity.

The deputy head of midwifery had received an inspiring individual runner up East of England chief midwife award.

The service had The Quality Improvement Project/ Plan (QIPP) tracker which contained all improvement work and actions required to support safety and quality. This include themes from incidents, complaints, women and birthing people feedback and audits. Staff told us this had helped provide an oversight on the elements of improvement taking place in the service and eradicate duplication.

The service had a human factors faculty which comprised of 8 maternity MDT staff who trained staff on several human factors that may cause an incident. The aim of the training was to encourage staff to think about embedding human factors understanding and knowledge into everyday life and clinical practice. The service was looking at expanding the human factors faculty team by appointing 8 more staff by June 2023.

The service was participating in a major clinical trial which aimed at improving the prevention of potentially life threatening infection caused by group b streptococcus in newborn babies. Senior staff told us that currently the service was among the second highest performing trust offering tests to pregnant women in this clinical trial.

The service had a sleep hygiene project which aimed at preventing sleep deprivation in mothers and promoting women's mental health. Women were given sleep packs which included items such as an eye mask, ear plugs and information leaflets on sleep.

Maternity

The maternity service had achieved the final UNICEF baby friendly level 3 status, which is considered gold standard to improve the infant feeding and relationship building experience of mothers and babies.

Outstanding practice

We found the following outstanding practice:

- The trust had invested in additional middle grade specialty doctors who were on-site and available 24/7. This was to ensure women and birthing people safety and improve their experience following consultation with MDT staff.
- The specialist bereavement midwife created a bereavement garden in the hospital grounds for bereaved parents of babies and children.
- The specialist midwife was caring and compassionate and gone above and beyond to develop the bereavement service for bereaved women and their families.
- The maternity service recognised and understood their women and birthing people groups and the additional challenges the women and families who accessed the service faced. Particularly around health inequalities, co-complexities and co-morbidities. As a response to these challenges, the service had created more specialist roles to support women in the hospital and community to improve the outcomes and experiences of the women.
- The access to information by women, birthing people, staff and public about the service, performance, policies and procedures was exemplary. Women and birthing people had access 60 information leaflets about pregnancy, condition and delivery. Women, staff and the public could also access 105 service maternity specific policies and guidelines on the website. The service had also created a maternity glossary of terms for women and several maternity areas tour videos which was available on their website for women to access. The information on the maternity website could be translated to any language.

Areas for improvement

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

Action the trust SHOULD take to improve:

- The trust should consider ensuring the bereavement room is sound proof to improve the experience of bereaved women and families who have experienced a loss.
- The trust should continue to improve the incidents reporting process in the service.
- The trust should continue to address the vacancy and sickness rates in maternity staffing.
- The trust should continue to address the high smoking rates of pregnant women at booking and post delivery.

Our inspection team

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