Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park 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 Arrowe Park 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 Arrowe Park Hospital.

We inspected the maternity service at Arrowe Park 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 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.

Wirral University Teaching Hospital NHS Trust is rated requires improvement.

We also inspected 1 other maternity service run by Wirral University Teaching Hospitals NHS Trust. Our reports are here:

Wirral University Teaching Hospital NHS Trust (also known as Seacombe Birth Centre) – https://www.cqc.org.uk/location/RBL18

How we carried out the inspection

During our inspection of maternity services at Wirral University Teaching Hospital NHS Foundation Trust we spoke with 20 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the antenatal clinic, maternity triage, labour ward, birth centre, day assessment, antenatal and postnatal ward. We reviewed the environment, maternity policies and 3 maternity 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. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign during our inspection to encourage pregnant women, birthing people who had used the service to give us feedback regarding care. We analysed the results of the eight responses we had back to identify themes and trends. These reflected a mixed response describing a kind and caring workforce but with some people experiencing delays to treatment and support during their stay in the maternity unit.

The trust provided maternity services at hospital and local community services and 2,975 babies were born at the trust during 2022.

Our findings

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

Maternity

Good ➔➔

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

Staff completed multidisciplinary training in key skills and responding to emergencies and worked well together for the benefit of women and birthing people. Staff understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to continually improving services.

However:

The service did not always have enough midwifery staff in triage. This was because the staffing model in triage required 2 midwives, but when acuity was low 1 midwife could be moved to a busier department. Because the acuity in triage was changeable and unpredictable, sometimes triage could become very busy and outside of office hours there could be delays bringing a second midwife back to triage.

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.

Most midwifery staff received and kept up to date with their mandatory training. Eighty seven percent of inpatient midwifery staff had completed all 13 mandatory training courses.

Most medical staff received and kept up to date with their mandatory training. Eighty one percent of medical staff had completed all mandatory training courses. Although the trust did not provide a target for mandatory training, they used a red, amber, green system to monitor compliance and when training was due. Managers monitored mandatory training and alerted staff when they needed to update their training.

The alongside midwifery led unit (MLU) had birthing rooms with pools. All staff who worked in the birthing centre had received up to date training in how to support a woman or birthing person in a pool evacuation emergency.

Maternity

The service provided staff with multi-professional simulated obstetric emergency training. Some staff had yet to complete this training, but 80% of midwives, 79% of consultant doctors and 92% of rotational doctors had completed the course. This training was themed around known risks and incidents within maternity services. For example, staff had emergency pool evacuation training and skills practice with a compliance rate of 90% for midwifery staff.

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. Ninety two percent of midwives and 86% of medical staff had completed CTG training and competency assessment.

The trust employed a practice development midwife and carried out a training needs analysis. This outlined training required for each role and frequency. A clinical preceptorship midwife supported band 5 newly qualified midwives through their preceptorship training programme.

Staff were supported to access and complete training by the practice development midwife. They organised regular skills and drills training based on themes and learning from incidents. Specialist midwives also provided short practice update sessions for staff.

The majority of staff we spoke with including newly trained midwives, experienced midwives and medical staff told us they were able to access the training they required and were positive about the training and support they received. A newly qualified midwife told us they felt very supported by all the band 6 and 7 staff and felt valued. However, some medical staff told they did not always have time to complete their 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 received training specific for their role on how to recognise and report abuse. Staff completed protecting vulnerable people (PVP) training level 3 and level 4. Training records showed staff had completed both level 3 safeguarding adults and level 3 safeguarding children training as set out in the trust's policy and in the intercollegiate guidelines. Ninety eight percent of midwifery staff and 88% of medical staff had completed this training.

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. For example, community links had been established with faith leaders from different religions. To help with safeguarding concerns, staff had access to and used interpreter services and language line for people whose first language was not English.

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 to be completed in the patients' 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. They gave us an example of a recent safeguarding concern and how this had been dealt with following all the guidance and protocols.

Maternity

The service employed a safeguarding specialist midwife and a safeguarding team who staff could turn to when they had concerns. The safeguarding specialist midwife had won a national award for outstanding leadership in safeguarding. Care records detailed where safeguarding concerns had been escalated in line with local procedures. The safeguarding lead worked closely with other professionals in the local area and attended monthly multiagency meetings.

One area of concern which was recognised was a risk of omission or inability to document the checking of child protection information sharing. This had been identified on the trust's risk register due to the current electronic records system not having comprehensive fields for documenting this information. To resolve this, an additional field was added to the system to ensure midwives had checked child protection information sharing systems.

Staff followed the baby abduction policy and undertook baby abduction drills. A baby abduction drill had taken place a week before our site visit to test the system and staff response. When we looked further into the process, we found the system for exiting the maternity ward was reliant on a staff member observing people if they left during office hours. We were concerned this system was not safe enough. The trust took immediate action and changed the exiting system so women, birthing people, and all visitors had to be let out by a staff member when leaving the ward at all times.

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

The service generally performed well in cleanliness checks. Cleanliness audits were carried out daily on all maternity wards and departments. Audit results showed a high compliance rate of 92% and above for April 2023 and 96.1% for hand hygiene and housekeeping audits carried out in the previous 3 months.

Staff followed infection control principles including the use of personal protective equipment. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas.

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.

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 environment was designed and fit for purpose. There was a day assessment unit, antenatal clinic area and triage area. Triage was open 24 hours a day with a dedicated phone line. There was a waiting area with comfortable seating and assessment rooms. Women we spoke with told us they were happy with this environment and found it comfortable.

Maternity

There was an alongside midwife led delivery suite and a consultant led delivery suite including an induction of labour suite. A maternity ward provided antenatal and post-natal care. A shared bay was used to care for postoperative women and birthing people and all other beds were in single rooms. One dedicated operating theatre was used for emergency surgery and 3 further operating theatres were available.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

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

There was a bereavement suite which was sound proofed and sensitively decorated and furnished. This provided bereaved women, birthing people and their families with the necessary space and distance from the rest of the department.

Staff carried out daily safety checks of specialist equipment. Records showed resuscitation equipment outside maternity theatres was checked daily. Records for February to April 2023 and resuscitaire checklist audits showed staff checked resuscitaires at every shift. However, we did see some gaps in daily checking records for resusitaires in triage and on the maternity ward.

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

The service had suitable facilities to meet the needs of women and birthing people's families. 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 was pool evacuation equipment and on the day assessment and triage unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. Leaders told us centralised CTG monitoring was being installed later in the year.

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

Risk was assessed at each maternity contact/appointment. We reviewed 3 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 and birthing people to be allocated to the right pathway, so the correct team were involved in leading and planning their care.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. This included the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 3 MEOWS records and found staff correctly completed them and, where indicated, had escalated concerns to senior staff. Staff completed a quarterly audit of records to check they were fully completed and escalated appropriately. Audits for March and April 2023 scored 100%.

Staff completed risk assessments for women and birthing people 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. The maternity triage waiting times for review audit for January to March 2023 showed midwives reviewed 100% of women and birthing people within 15 minutes of arrival.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. There was a fetal surveillance lead and 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). The January to March 2023 audit showed clear interpretation and management plans following CTG and staff did 'fresh eyes' at each hourly assessment in 72% of cases. Compliance with CTG and 'fresh eyes' was monitored monthly.

Audits were carried out to check risk assessments and other key areas. For example, maternity harm prevention audits, sisters' audits, care metric audits and surgical safety checklist audits were carried out monthly. Compliance rates were high and where issues were identified, action was taken to increase safety and compliance.

Women and birthing people had access to the scans they required and there were enough sonographers and scanning equipment available. Additional scanning appointments were made available if required.

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. Specialist mental health midwives and support workers were part of the team. They attended multiagency meetings with mental health professionals and supported women and birthing people across a range of mental health needs.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was held on a secure electronic 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 with multidisciplinary teams.

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 2 safety huddles a shift 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 women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation (known as S-BAR) for each person.

Staff completed new-born risk assessments when babies were born using recognised tools and reviewed this regularly. New-born and infant physical examination clinics were held daily on the maternity ward and staffed with midwives who had additional training to carry out these checks.

Maternity

The service provided transitional care for babies who had additional needs. Four rooms on the maternity ward were used for transitional care and these were staffed with neo natal trained staff.

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.

Women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff completed risk assessments for women and birthing people on arrival to the triage department. They used a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The maternity triage waiting times for review audit for January to March 2023 showed midwives reviewed 100% of women and birthing people within 15 minutes of arrival.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had no current risks with recruitment, retention and staff sickness. Staffing levels usually achieved the planned numbers. At times when staffing numbers were short, an escalation pathway was followed to make leaders aware of staffing needs in each area and to organise appropriate cover. Some staff were moved from their usual working areas to cover staff shortages in other areas. When the triage area was not busy, the second midwife was moved to support busier departments, However, this left one midwife and a ward clerk to deal with incoming calls and to assess women and birthing people as they arrived. This had not led to any known delays in assessment, but some staff told us they felt it was not always safe.

Midwifery staff were organised into continuity of carer teams (where women and birthing people received dedicated support from the same midwifery team throughout their pregnancy) and core teams of midwifes based within maternity wards and departments. Six teams were embedded and established. The teams were based in localities which supported harder to reach and vulnerable communities. The service had plans to reach 100% continuity of carer by September 2024. Staffing needs were assessed daily against the clinical and other needs of the women and birthing people (acuity) expected.

The service last completed a staffing and acuity review in December 2022. It said the service met acuity needs 78% of the time against a trust target of 85%. To respond to this, a recruitment and retention midwife had been recruited to attract new staff and support existing staff within maternity services. There were proactive succession plans to address any shortfalls in numbers or skill mix to provide safe care to people who used the service. The vacancy rate for midwifery, nursing and medical staff was comparably low.

Staff turnover rates were low and were decreasing. For example, the staff turnover rate in November 2022 was at 15.3% and this had reduced to 11.8% in April 2023. The service did not routinely use agency staff. NHS bank staff who were familiar with the service were used as required.

Maternity

There had been 6 red flag events in the last 6 months. A red flag event is a warning sign that something may need attention in midwifery staffing numbers or skill mix. We saw how the red flags were recorded and managed to consider themes or areas where staffing had dropped below the required level (2 occasions). Other red flags recorded in the last 6 months included a delay in administering antibiotics and a delay in carrying out a new-born screening check.

We looked at the most recent staffing report sent to the trust's board which reported staffing and absence and planned versus actual staffing in the maternity departments. It showed no reported trends of any staffing issues within maternity services.

There were supernumerary shift coordinators on duty 24 hours a day who had oversight of the staffing, acuity, and capacity. The labour ward coordinators were also supernumerary.

Managers requested bank staff familiar with the service and made sure all bank and agency staff, if used, had a full induction and understood the service.

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

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. The staff appraisal compliance was at 100%. A practice development team supported midwives. They were responsible for ensuring the required levels of training attendance and competence were achieved. They had an escalation process for any staff who did not attend planned training. The practice development team had been recognised and won an award for the practical obstetric multi professional training delivered in 2022. Incidents and events were used within the training to provide practical learning opportunities.

There were a number of specialist midwives to support different aspects of the service such as surveillance, mental health and bereavement. Managers made sure staff received any specialist training for their role. As well as supporting the staff, specialist midwives also provided practice update training sessions for staff.

The service had specialist midwifery services and clear guidelines for the care of women with mental health problems, teenage pregnancies, substance misuse, bereavement services and infant feeding.

Ten midwifes had completed additional training in enhanced critical care to support the 2 high dependency beds on the delivery suite.

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 on duty achieved the planned number. The service had comparably low vacancy, turnover and sickness rates for medical staff.

Maternity

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, nights and weekends.

Medical ward rounds were carried out twice a day so women and birthing people could be assessed, and their care reviewed. Medical staff involved woman and birthing people in decision making about the plan of care. Ward rounds were comprehensive and women and birthing people were given the time they required to ask questions or raise concerns.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop. Consultant rotas included allocated time for supporting professional activities as well as direct clinical care.

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 clinical records were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 3 sets of patient records, 3 of which were in the electronic system and 3 which were the linked paper records. We found the records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Electronically stored records could be accessed throughout the hospital so staff in different departments could access this information. To support this, the trust had recruited a midwife to lead on the digital role. There was an information technology (IT) steering group and transformation group with plans in place to upgrade IT systems and record keeping. Women and birthing people did not have direct access to their digital records, but development was underway for access to these to be provided from summer 2023. However, women and birthing people did have handheld notes.

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

Medicines

The service used systems and processes to safely prescribe, administer, record medicines. However, staff did not always ensure all stock medicines were within expiry dates.

Staff followed systems and processes to prescribe and administer medicines safely. The service used an electronic prescribing system. Women and birthing people had electronic charts for medicines to be administered during their admission. We reviewed 3 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.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. Midwives could access the full list of midwives' exemptions for medicine prescribing, 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 stored at the correct temperature. Staff checked controlled drug stocks daily. There was central monitoring for fridge temperatures and staff would be alerted and knew how to act if there was any variation to safe temperatures.

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 both paper and digital systems for the 3 sets of records we looked at were fully completed, accurate and up to date.

However, we found some medicines had passed their expiry dates in three areas. Leaders took immediate action and carried out a full check of all medicine stocks in all maternity departments. As well as this, as a result of our feedback, the frequency of audits of all medicine cupboards and fridges was increased from monthly to fortnightly.

Incidents

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

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

In the last 3 months, 2 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation under the guidance for referring certain events. The investigation into these incidents was ongoing. However, a rapid review had been carried out by the trust and additional training had already been implemented in response to one incident.

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

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Weekly care improvement meetings took place to review incidents. Any identified learning or care improvements were shared with staff. Incident reporting was encouraged and used as an opportunity to learn and improve services.

Staff understood duty of candour requirements. They were open and transparent and gave women and birthing people and families a full explanation if and when a notifiable safety incident occurred. 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. All incidents were reviewed by the clinical governance team and with a 10-day target to complete duty of candour and provide a written explanation.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations as our review of 3 serious incident investigations showed. In these 3 investigations, managers offered an apology and explanation under duty of candour regulations, and shared draft reports with the families for comment.

Maternity

Managers reviewed incidents potentially related to health inequalities through the incident investigation process. Leaders acknowledged this could be strengthened and improved and had plans to do this when changing to the new NHS patient safety incident response framework (PSIRF) for incident reporting.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at an obstetric clinical governance meeting in January 2023. As a result of this incident, leaders ensured staff had access to carbon monoxide (CO) monitors and reminded midwifery staff that CO readings must be completed at each contact/appointment with women and birthing people.

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. Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good 

Our rating of well-led stayed the same. 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. The service was led by a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology – often referred to as 'the triumvirate'. They were supported through clear professional arrangements. There was joint working between leaders within maternity, the wider trust, and external agencies and bodies to maximise care provision for women, birthing people and babies.

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.

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 the director and head of midwifery were approachable and accessible. 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 the Board via the maternity safety champions which included the Chief Nurse and a non-executive director. Safety champions carried out 'walkabouts' within maternity services to speak with women and birthing people and with staff.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

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

There was a maternity vision and a set of core commitments which underpinned the trust's 5 year maternity clinical services strategy**.** Leaders had developed the vision and strategy in consultation with staff at all levels. Further work had commenced to increase staff knowledge and involvement with the maternity vision and this was displayed in the maternity departments.

Leaders had considered the recommendations from the NHS Ockenden 2020 and 2022 reports on the review of maternity services. They had developed and implemented essential actions as well as revising their 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. These led to continuity of care teams being well established and being developed further. Also, woman and birthing people had a choice of birth location depending on risk assessment.

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 were positive about the department and its leadership team and felt able to speak to leaders about difficulties and when issues arose.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture placing people's care at the heart of the service. They recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and demonstrated by all staff we observed and spoke with. Feedback from women and birthing people following was mostly positive during our site visit and following this inspection. Two women told us they had to wait a long time for pain relief to be given.

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. The 2022 maternity survey results showed the general level of care reported for this trust was positive.

Maternity

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 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.

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 initially used the most informal approach applicable to deal with complaints. Complaints and the response to complaints was a standard agenda item at monthly clinical governance meetings.

We reviewed 2 responses to complaints received and found these were thorough and responded to well.

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.

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

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 sub-committees and all staff. Following any incidents or shortcomings in care or processes, action plans were developed with clear timescales and responsibilities.

There was clear oversight of the service with appropriate lines of reporting to various meetings. For example, there were monthly clinical governance meetings which had oversight of all known or emerging risks. There was a clear line of communication between the service and the trust board. A monthly maternity report was presented to the board of directors providing an update for quality and safety metrics within maternity services and identifying any key risks or required actions.

Maternity

There was a learning culture when incidents occurred or something went wrong. Staff were encouraged to use the electronic reporting system to report any incidents so they could be analysed and used to learn and improve. A midwife leading on risk held weekly meetings to increase learning from incidents.

Staff followed current 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 current and followed the latest guidance.

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. Managers and staff used the results to improve women and birthing people's outcomes. The Ockenden assurance visit of August 2022 found compliance with the 7 immediate and essential actions to improve care and safety in maternity services.

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. Care improvement meetings were held weekly and reviewed incidents across the trust including maternity services.

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 changes where risks were identified.

The maternity risk register, perinatal mortality review reports and healthcare safety investigation reports, clinical incidents and audits were a standing item at monthly clinical governance meetings for review and action planning. These were used to identify and manage known risks and were reviewed at monthly trust board meetings and presented to the board of directors every quarter by the director of midwifery. There was a team of safety champions (including a non-executive director and the director of midwifery) who attended monthly meetings and completed walk abouts withing maternity services to speak with women, birthing people and staff.

There were plans to cope with unexpected events. The service had a detailed local business continuity plan. Leaders worked closely with other local maternity departments to support each other when maternity services were busy.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Listening events and team meetings routinely took place and staff told us they were asked for their feedback and input.

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**.** The service 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 to compare performance. Clinical governance reports with statistics on quality, safety and performance were published and displayed in all the maternity areas for all staff to see.

The hospital trust provided staff with the systems and data to access the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

At the time of this inspection woman and birthing people did not have personal access to their clinical records through the hospital's system but changes planned to the IT system would enable this to happen. However, women and birthing people had maternity handheld notes**.** Development was underway for digital access to be provided from summer 2023".

The information systems were integrated and secure**.** Electronic records were protected by security access and only those staff with authorisation were able to see medical records.

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.

The voices of women and birthing people were considered within key decisions. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The trust were supportive of the MNVP, met with them frequently and involved them in key decisions affecting maternity services. This included, for example, the recruitment of new leaders.

Leaders understood the needs of the local population. Listening events took place within the local community and in multicultural centres to promote inclusion to all people.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The experience of woman and birthing people of using interpreter services was discussed and explored so changes could be made to meet needs. Discussions were underway to further develop antenatal education into other languages and the translation of maternity information to include cultural differences. Staff also used a telephone interpretation service when required, which was available 24 hours a day, every day. Information on social media was also available in other languages.

Social media was used to engage with the local community. This included live-streamed tours of the service and women and birthing people were able to make comments and ask questions. Changes were made in response to what people said or asked for. For example, the décor was changing in the birth centre to make it more welcoming in response to people's feedback. Important antenatal education messages such as 'what to do if fetal movements are reduced' were recorded by staff who could speak other languages and put on social media for people to access.

Listening events and staff meetings took place to engage with staff, communicate changes and listen to their views and experience. For example, listening events had covered topics such as staff work life balance and managing finances.

Learning, continuous improvement and innovation

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

The service was committed to improving by learning when things went well or not so well and promoted training and innovation. Learning was shared with staff through monthly clinical governance newsletters and staff social media platforms. These contained information about recognised risks and incidents; learning from care improvements meetings; complaints; staff and patient feedback; and nationally produced healthcare safety investigation branch reports. Staff were remined how to report incidents and about governance issues such as 'duty of candour.' The newsletter was also used to recognise staff achievements and good practice.

The trust was the only service within the local maternity services network to offer 4 birth choices to woman and birthing people.

The service had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

There were a team of enhanced care trained midwives with at least one enhanced care trained midwife working on the delivery suite at all times. This was planned to reduce the need to transfer woman and birthing people to intensive care or high dependency units.

Designated infant feeding support staff were available on every shift to provide support to woman and birthing people.

Funding had been secured for an application and new IT software to improve communication in other languages and antenatal education.

There was a team of 3 midwives with a specialist role in mental health support. Midwifery mental health services were being devolved to provide increased support with anxiety and mental health wellbeing. For example, weekly 'singing mammas' groups were offered to antenatal woman (singing mammas groups are designed to improve mood, reduce stress and promote connections). Mental health midwives were attending training so hypnobirthing and a technique known as 'emotional freedom' could be offered. Virtual reality headsets were available for relaxation and medication sessions.

The midwifery team had been awarded a team excellence award by the trust.

Maternity

Outstanding practice

We found the following outstanding practice:

The Maternity and Neonatal Voices Partnership (MNVP) Chair was well supported and received 16 hours per week funding. The relationship between the MNVP chair and leaders was strong and inclusive. The MNVP chair had access to leaders at all times and they responded quickly and efficiently to any concerns raised. The MNVP chair was involved in the recruitment of leaders and encouraged to attend regular meetings to feedback the voices of woman, birthing people and pregnant people. They were involved in a number of initiatives designed to reach out to all groups within the local community.

Areas for improvement

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

Action the service SHOULD take to improve:

Location/core service

- The service should ensure the staffing model and deployment used in triage does not delay access to assessment and treatment.
- The service should ensure there are no out of date medicines within medicine stocks.

Our inspection team

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