Royal Berkshire NHS Foundation Trust

Royal Berkshire Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal Berkshire Hospital

Good 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Royal Berkshire Hospital.

We inspected the maternity service at Royal Berkshire 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.

The Royal Berkshire Hospital provides maternity services to the population of Reading and West Berkshire.

Maternity services include a fetal medicine unit, outpatient department, maternity assessment unit, Marsh antenatal ward, central delivery suite, Rushey midwifery led birth centre, 2 maternity theatres, Iffley postnatal ward and an ultrasound department. Between April 2023 and October 2023 2,721 babies were born at Royal Berkshire Hospital.

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 rating of Good for maternity services did not change ratings for the hospital overall. We rated safe and well-led as Good.

How we carried out the inspection

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

We visited the maternity assessment unit, central delivery suite, maternity theatres, midwifery led unit and antenatal and postnatal wards.

We spoke with 3 doctors, 14 midwives and managers, 3 support workers, and 2 women and birthing people. We received 16 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 5 patient care records, 4 observation and escalation charts and 6 medicines records.

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

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

Maternity

Good ➔➔

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

However:

- The design of the environment was not always suitable. During our inspection, we raised concerns regarding the security of Marsh and Iffley wards. The service took immediate action to ensure the wards were secure.
- Planned and actual midwifery staffing numbers were not always equal to each other.

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.

The service had a maternity specific mandatory training policy; it was version controlled and was last updated in September 2023. The policy included a training needs analysis which outlined all training required to be completed by

maternity staff. The training needs analysis was linked to national recommendations such as the national core competency framework version 2 and saving babies lives version 3. It set out the responsibility of staff for compliance and monitoring of mandatory maternity training completion. The training needs analysis, core competency framework for the next 3 years showed the compliance required to meet the recommended standards.

Health inequalities were identified in the training needs analysis and the service provided bespoke training relating to inequalities affecting their population.

Staff received and kept up to date with their mandatory training. The trust target for mandatory training was 90%. Medical staff overall compliance with training was 87% which was just below the trust target. Nursing and midwifery staff compliance with training was 91% which met the trust target.

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 neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Staff completed annual multidisciplinary obstetric emergency training. The training included a Practical Obstetric Multi-Professional Training (PrOMPT) training day and a locally developed, community emergency training day in partnership with the local ambulance NHS trust. Ninety two percent of midwives had completed this, 91% of maternity support staff, 96% of anaesthetic staff and 75% of medical staff.

The service provided training and competency based assessments on fetal monitoring and the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Nursing and midwifery staff compliance was 94% and medical staff compliance was 80%.

Staff had mostly completed appropriate advanced life support and neonatal advanced life support training. Neonatal life support training was included in the multidisciplinary obstetric emergency training. Compliance with maternity specific adult resuscitation training was 90% for midwives, 93% for maternity support staff, 84% for medical staff and 89% for anaesthetists. This meant that most staff had training to provide lifesaving treatment to women and birthing people and babies in their care.

The service provided pool evacuation training using video review. Following our inspection, the service provided updated information that showed 84.9% of staff had completed pool evacuation training. The training video was added to the induction for all staff in intrapartum areas and included in mandatory PrOMPT training. The service planned regular skills and drills training, which included evacuation from a pool. The last pool evacuation simulation had taken place in February 2023 with one planned for February 2024.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they were given dedicated time to complete mandatory training. The service had an education and training team of specialist midwives. This included 6 practice development midwives and maternity support workers, a fetal monitoring lead midwife, and lead midwives for internationally educated midwives, collaborative learning, obstetric anal sphincter injury and postpartum haemorrhage. The team supported staff to access mandatory training and alerted them when this was due.

Maternity

The service set up a multi-professional education team (MET) in August 2023. The MET team included different staff members from the maternity practice development team, obstetric, anaesthetic and neonatal teams, service user involvement and quality and compliance leads. The team reviewed all training plans, agendas and lesson plans to ensure that the 4 key principles of the core competency framework were covered.

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. The trust target for safeguarding training was 90%. Medical staff overall compliance with safeguarding training targets was 88% for level 3 adults and 90.5% for level 3 children. This was just below the trust target.

Nursing and midwifery staff compliance with training targets was 90% for level 3 adults and 93% for level 3 children. This met the trust target.

The service had a safeguarding, mental health and learning disability training plan for 2023-24. This aimed to ensure staff had a robust, reliable working knowledge of safeguarding procedures and practices and appropriate knowledge and skills in relation to working with people with learning disabilities and mental health needs. We looked at the contents of this training plan and saw it covered the expected modules for level 3 training. However, staff told us that the Oliver McGowan mandatory training on learning disability and autism had not yet been rolled out to maternity services by the trust. Following our inspection, the service told us all staff received learning disability and autism training during trust induction which included elements of Oliver McGowan training. Tier 1 Oliver McGowan training was available to staff on the trust e-learning platform and they were working with the local integrated care board to develop the tier 2 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. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics, for example through the ‘seeking sanctuary’ project for migrant, asylum seeking and refugee women, birthing people and families.

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. We saw this recorded in care records we reviewed, or a note made ‘unable to ask’ so this could be followed up at subsequent contacts.

Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team. There was a system to ensure a safeguarding referral was made for all women or birthing people who booked pregnancy care late and the safeguarding team attended daily ward rounds. Staff told us they were given comprehensive safeguarding plans to follow, where appropriate.

Maternity

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns and staff could access support from a lead midwife for safeguarding and lead nurse for child protection. Staff we spoke with told us the safeguarding team were approachable and visited the ward frequently.

Midwives working in the 'poppy' team supporting vulnerable women and birthing people received safeguarding supervision every 6 weeks from the safeguarding team. The safeguarding team received regular safeguarding supervision from the integrated care board and linked with the local case review group and other safeguarding professionals, attending a monthly vulnerable pregnancy meeting with system partners.

Care records detailed where safeguarding concerns had been escalated in line with local procedures. We saw care records detailed shared information regarding safeguarding and health inequalities from GP care records.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and described the outcome of a recent drill.

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. All areas we visited were visibly clean and dust free. There were dedicated housekeeping staff in each area. Bed areas had disposable curtains with clearly displaced replacement dates.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service generally performed well for cleanliness. The housekeeping team carried out regular cleaning audits, these were weekly on central delivery suite, day assessment unit, maternity theatres and Rushey ward and monthly on Marsh and Iffley wards. We reviewed cleaning audits of delivery suite and day assessment unit for August to October 2023 and saw compliance was between 99.7% and 100%. Compliance for maternity theatres was between 98.7% and 100% and for Marsh and Iffley wards was 99.7%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. Data showed hand hygiene audits were completed every month in maternity areas. We looked at audits for delivery suite, Marsh and Iffley wards and Rushey midwife led unit for August to October 2023 and saw compliance was consistently above 98%. We observed staff followed 'bare below the elbows' guidance.

The infection control team carried out an annual infection prevention and control audit. We reviewed the audits for central delivery suite, maternity theatres and Marsh and Iffley wards. We saw the audit was comprehensive and covered areas such as cleanliness and maintenance of equipment, hand hygiene facilities, the physical environment and toilet and bathroom facilities. Most aspects showed full compliance and the service had an action plan to address all areas of lower compliance with clear action owners, target dates and evidence requirements.

Staff cleaned equipment after contact with women and birthing people and used green 'I am clean' stickers to indicate equipment was clean and ready for use. Staff carried out daily flushing of water outlets to prevent the spread of legionella.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the design of the environment was not always fit for purpose.

Call bells were accessible to women and birthing people if they needed support. Women and birthing people we spoke to told us staff responded quickly when called.

The maternity unit had a monitored entry and exit system. However, during our inspection we found that though ward areas had secure access and doors were monitored, people could leave Marsh and Iffley wards using a push button and without being challenged. The main entrance had 24-hour security guard presence with cameras but this was left unattended several times during our inspection, and it was possible to access other parts of the hospital without being seen. We raised our concerns with leaders during our inspection who took immediate action to address the risk. This included additional risk assessment, ensuring everyone leaving the unit was escorted by a member of staff and security being notified of all people authorised to leave the unit so they could challenge anyone not accompanied by a member of staff. The service added the security of the unit to the risk register so longer terms solutions could be found and monitored. Following our inspection, the service installed a staff controlled exit system to ensure the wards were secure.

The theatres and recovery area were shared with the gynaecology department. This meant women and birthing people recovering from a general anaesthetic had the initial 30-minute recovery period whilst still in theatre.

Staff mostly carried out daily safety checks of specialist equipment. We saw adult resuscitation trolleys were checked daily. However, there were some gaps in daily checks of resuscitaires on Iffley and Marsh wards. Resuscitaires and resuscitation trolleys we checked had all the required items present, with none out of date.

The trust had a system to monitor environment and equipment safety checks which were completed and we saw evidence of action taken to remove or replace equipment which did not pass these checks.

Suicide and self harm risk assessments, which included assessment of ligature point risks, had been completed for maternity services and showed controls in place to minimise risks.

Staff regularly checked birthing pool cleanliness and a standard operating procedure for pool cleaning was displayed in the room.

The service had suitable facilities to meet the needs of women and birthing people's families. There were shower and bathing facilities available to women and birthing people that met their needs. The birth partners of women and birthing people were supported to attend the birth and provide support. On Iffley ward there were kitchen facilities for women, birthing people and families to use. There was an infant feeding room with facilities for women and birthing people to express breast milk and feed their baby comfortably.

On Rushey midwifery led unit there was an 'early labour' room. This could be used by women and birthing people in early stages of labour, before they needed admission to delivery suite or a birthing room in active labour. This was especially useful for women and birthing people who experienced anxiety or who had long distances to travel.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there were pool evacuation nets in all rooms with a birthing pool. There were nitrous oxide scavenging systems in all birthing rooms. A scavenging system is a way to collect and remove excess gas to prevent harm to people from prolonged exposure.

During our inspection we saw, a resuscitaire on Iffley ward was overdue its service date and waiting repair. The service was monitoring the risk related to overdue servicing of resuscitaires on Marsh and Iffley ward through the service's risk register.

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.

The service audited compliance with safe waste handling and disposal as part of the annual infection prevention and control audit. The most recent audit was completed on delivery suite in June 2023 and showed full compliance in all areas of waste handling and disposal.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and 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 women and birthing people. We reviewed 4 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff.

Staff completed audits of records to check they were fully completed and escalated appropriately. The audit for October 2023 showed 71% of observations were completed on admission, 93% compliance with daily observations and 52% compliance with the escalation of concerns following observations. The service had an action plan in place to improve staff compliance with completion and escalation of MEOWS. Following our inspection, staff in the service told us the audit tool used was being reviewed as they had identified inaccuracies in the data. There was no patient safety data which showed escalation was a concern. The service was working to improve the audit plan, including changes to electronic patient records to ensure audit data could be easily accessed.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service had introduced use of an evidence-based, standardised risk assessment triage tool in maternity assessment unit. This was a RAG (colour coded) tool to support midwives to identify immediate and high-risk patients. Formal training had been given to all midwives working in the area to ensure practice was embedded.

Leaders monitored waiting times to make sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. The service used experienced midwives to answer triage calls to ensure the safe assessment of women and people. The telephone line was based in its own office and used specialised telephone call software. All calls were recorded on the patient record. There was a system to monitor all calls including drop off rates and an automated message to direct women to the correct area.

Maternity

The service had audited waiting times for initial triage for October 2023 following the implementation of the new system. In October 2023 63% of women and birthing people were triaged by a midwife within 15 minutes of arrival against a target of 80%. However, this was an improvement from 54% in August 2023 and the service had an action plan to continue to improve performance against this target. Following our inspection, the service provided evidence that improvement had continued with 68% of women and birthing people seen within 15 minutes in December 2023. The audit for October 2023 showed 99% of women and birthing people rated green (lowest risk), 91% of women and birthing people rated yellow (medium risk) and 76% of women rated orange (higher risk) had an ongoing assessment within the designated timeframe.

There was a process for the prioritisation and ongoing assessment of women and birthing people having induction of labour. The service had an 'early bird' team of maternity support workers on each shift. They supported the timely discharge of women, birthing people and babies from the unit by ensuring all necessary assessments, paperwork and medicines were completed. The service had a midwife allocated to complete Newborn and Infant Physical Examination (NIPE) screening 7 days a week.

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 July 2023 audit showed CTG reviews were completed in 97% of the cases and abnormal results escalated in 83% of cases. It showed staff did 'fresh eyes' at each hourly assessment in 81% of cases.

There was a clear process to review women or birthing people who wished to birth outside of guidance with individual birth plans in place.

The audit of maternal sepsis in 2023 showed 85% of women and birthing people received antibiotics within an hour. This is important because if sepsis is not treated early it can cause septic shock and cause organ failure, with an increased risk of mortality. There had been no maternal deaths.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and audits for August to October 2023 showed 100% compliance with all elements. There was also a bi-annual observational audit completed in October 2023 which showed 100% compliance.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn early warning trigger and track (NEWTT) tool is designed to be used by healthcare professionals working in areas caring for newborns in the early and ongoing postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NEWTT from July to September 2023, this showed 88% of babies had a risk assessment at birth and 81% had the NEWTT scored correctly. This was against a target of 80%. However, there was only 48% compliance with NEWTT completion within required timescales and 36% compliance with escalation to paediatric doctors. Though this meant there was a risk babies at risk of deterioration may not be identified in a timely way and the right care and treatment given, rates of admission to the neonatal unit were below the national average, indicating identification and escalation of neonatal concerns did happen. The service told us data was from a pilot audit which was under review due to inaccuracies in the data. Following our inspection, the service reviewed records of the babies included in the audit and found evidence that appropriate escalation had taken place.

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. We saw a mental health assessment had been completed in all records we reviewed.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the woman'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. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. We reviewed audits of handovers between May and September 2023, which showed 97% compliance with SBAR completion.

The service provided transitional care for babies who required additional care on Marsh ward. This was staffed by neonatal nursery nurses and midwives.

Midwifery Staffing

The service mostly 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.

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The service's maternity dashboard showed 100% compliance with the labour ward coordinator being supernumerary from March to October 2023 and that 1:1 care in labour was provided 100% of the time.

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. Between May and October 2023 there were 150 red flag incidents, most of these (77%) related to a delay between admission for induction of labour and the beginning of the process. The service had an induction of labour suite with 24 hour dedicated staff who invited women and birthing people into the unit when there was a bed available at any time within 24 hours. Following our inspection, the service told us they used a lower threshold for monitoring red flags than NICE guidance and therefore delays in induction of labour did not relate to the NICE red flag criteria but to delays in being able to transfer to the delivery suite. They told us they did not have delays in induction of labour related to the NICE criteria.

However, staffing levels did not always match the planned numbers. The service provided data to show that between March and August 2023 staffing matched acuity on central delivery suite for 68% of the time. To ensure staffing met acuity at other times the service had a clear escalation policy which included suspension of births on the midwifery led unit and redeployment of staff from community and other inpatient areas. The service provided information to show mitigating actions were taken to maintain safety when staffing did not match acuity.

Maternity

The maternity dashboard for April to October 2023 showed the option to birth on the midwifery led unit was suspended for 4 hours or more on 112 occasions due to staff not being available.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. The service last completed a staffing and acuity review in March 2023. It said the service mainly had enough staff to meet the planned needs of women but needed a further 2 whole time equivalent (WTE) midwives due to a review of the safety and compliance team structure. The review recommended a full acuity assessment using a nationally recognised staffing and acuity model should be completed in April 2024.

Managers could adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice. Following our inspection, the service told us they only moved staff to areas they were familiar with and provided a full orientation, with support from the shift coordinator. However, some staff told us they had been moved to areas they were unfamiliar with at times. . Managers attended a daily operations meeting to look at acuity and staffing in each area. We attended the meeting and saw staff were moved to cover sickness absence and acuity in different areas. We saw managers discussed skill mix, the plan ahead for night and where additional support was needed.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. From October 2023, the service had a maternity coordinator 24 hours a day 7 days a week. This was a supernumerary midwife with oversight of staffing and acuity across the unit and who reported to the trust's daily operational meeting. They also provided additional clinical support at the times when the most staffing red flags had occurred, at nights and weekends.

The service had improving turnover rates over the last 12 months. The turnover rate for midwives had improved from 19% in July 2022 to 9% in August 2023, which was below trust target. Within the budget established for midwives the service had an uplift of 22% to cover sickness, annual leave and training. The sickness absence rate in August 2023 was 3.9% and annual leave accounted for 15%, leaving the rest for training. Sickness absence rates had increased each month since April 2023.

The midwifery staffing report to trust board showed the vacancy rate for midwives in September 2023 was 13.6%. This was a reduction from the previous month due to recruitment which included internationally trained midwives.

The service told us the retention of internationally trained midwives was a challenge, and this had been added to the risk register. The service had run listening events with midwives and developed an action plan to address this.

We looked at the most recent staffing report sent to the trust's board which reported the service had a clear operational and escalation policy to mitigate staffing issues. There was a recruitment and retention plan to improve and maintain midwifery staffing and this was reported monthly to the trust's Nursing, Therapies & Maternity Retention and Recruitment Committee. The service had a recruitment and retention midwife to support training and preceptorship.

The service had developed additional roles within maternity to address the difficulties in recruiting enough midwives. For example, they had recruited maternity nurses who were band 5 nurses with additional maternity training to care for post operative women and birthing people and neonatal babies.

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.

Maternity

The service did not have a designated recovery nurse team for women and birthing people following a general anaesthetic for emergency caesarean section. The service told us the midwife that supported the woman or birthing person in theatre was responsible for recovery care. All women and birthing people that have a general anaesthetic were woken up in theatre and recovered by the anaesthetist for a minimum of 30 minutes before returning to the delivery suite. The anaesthetist ensured they were safe to return to delivery suite and one to one care was provided in this period by a midwife and maternity support worker. The service told us they were working with planned care, the obstetric anaesthetic lead and theatre staff to review management of recovery care and monitoring this through the risk register.

Managers made sure staff received any specialist training for their role. All midwives attended a 2-day theatre placement as part of their orientation programme. This included 1 day following the elective caesarean section list and a second day working in the maternity recovery area with a workbook to complete. Midwives also completed epidural and post theatre care competencies, which were signed off by an anaesthetist.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service provided information that showed 92.5% of midwifery and nursing staff had completed an annual appraisal.

The maternity unit education and training team supported all members of the multidisciplinary team. This included 6 practice development midwives and maternity support workers, a fetal monitoring lead midwife, and lead midwives for internationally educated midwives, collaborative learning, obstetric anal sphincter injury and postpartum haemorrhage.

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 delivered 162 hours of consultant presence per week and had a hybrid rota of consultant working which ensured all consultants provided a variety of resident and non-resident cover out of hours. Consultant presence on delivery suite and twice daily consultant ward rounds was monitored monthly and reported on the maternity dashboard.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service followed Royal College of Obstetricians and Gynaecologists guidance on scenarios which required consultant presence.

The service always had a consultant on call during evenings and weekends. There were clear procedures for staff to follow to request consultant presence at difficult deliveries. The service had 24-hour access to an anaesthetist 7 days a week.

The service had low vacancy, turnover and sickness rates for medical staff. The overall sickness rate for May to November 2023 was 3.3%, this equated to 150 registrar, senior house officer and consultant shifts impacted by sickness absence.

The service had 3 vacancies for registrars and recruitment was underway. There were no gaps in the consultant rota. However, the service was in the process of recruiting an additional consultant to support women and birthing people experiencing complex pregnancies. Staff told us gaps in rotas were proactively managed through the use of locum doctors.

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. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

Between May and November 2023, 100 medical shifts were covered using internal bank staff. During the industrial action, consultants filled gaps in middle and junior grade rotas. All doctors in the locum 'bank' (known as patchwork) were either doctors currently employed by the service and working in the department, or doctors who had worked in the department in the last 2 years. The service did not use any agency locum doctors.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The service provided information that showed 87% of medical staff had completed an annual appraisal.

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 electronic records. We reviewed 5 electronic records and found records were clear and complete.

The service took part in the trust wide record keeping audit for October to December 2022. This showed full compliance with trust standards apart from contact details of author being clearly documented.

From April 2023, the service included a self-assessed record keeping audit as part of the annual appraisal process for midwives. In April 2023, the service launched a new audit tool for auditing maternity record completion in line with Nursing and Midwifery Council standards.

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.

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 6 prescription charts and found staff had correctly completed them.

The service had reviewed its approach to medicines management training and ensuring the competency of staff in medicines management. From October 2023, all midwives completed an intravenous therapy study day which included intravenous antibiotics, intravenous medicines for babies, epidurals and blood transfusion. This had previously been

included in the induction programme for midwives. The service implemented medicine management assessment for all new midwives and this was used to facilitate learning as part of reflective practice after a drug error for all midwives. The service did not provide figures for current compliance for midwives with medicines management training and competency but told us they had plans to retrospectively review all midwives' compliance.

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.

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

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks twice daily. Staff monitored and recorded ambient room temperatures and knew to act if there was variation. Fridges which stored medicines had an external temperature display and a system which automatically alerted pharmacy if the temperature fell outside range, so corrective action could be taken.

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 digital systems for the 6 sets of records we looked at were fully completed, accurate and up to date.

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. Staff reported serious incidents clearly and in line with trust policy. The service reported 4 serious incidents to the Strategic Executive Information System (STEIS) between April and October 2023.

The service had 1 never event in November 2023 which did not cause harm to the patient. 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. This was reported through national NHS incident reporting systems and investigated by managers.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. They discussed and reviewed incidents at the daily operational meeting and escalated for further investigation, as appropriate.

Between June and November 2023, the service identified 7 incidents which required referral to the Maternity and Newborn Safety Investigations programme (MNSI), formerly HSIB. Of these, in 2 cases the family declined the referral and stated they had no concerns.

Maternity

We reviewed investigation reports and associated action plans for 3 incidents investigated by MNSI. We saw all had no key safety recommendations and action plans addressed key findings in the reports. This included how learning would be shared with staff through methods such as presentations and additional training.

Managers reviewed incidents potentially related to health inequalities. The service monitored incidents referred to MNSI by ethnicity, postcode and deprivation score so they could identify any trends or themes for vulnerable groups. The service considered ethnicity when reviewing perinatal mortality and admissions to the neonatal unit to assess if this was a factor in each case and to identify any themes.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We saw parental perspectives were included in all perinatal mortality reviews and discussed at the perinatal mortality review meetings.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Staff could describe the 'open and honest' policy and how to ensure duty of candour was carried out appropriately.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, feedback from incidents was shared on the quality and safety board displayed on each ward. This included numbers of incidents reported, learning from incidents in that area, learning form incidents across the unit and outcomes of investigations.

There was evidence that changes had been made following feedback. Staff explained and gave examples of changes made to medicine rounds following a medication incident.

Managers debriefed and supported staff after any serious incident. We heard how the safeguarding team supported staff involved in any incidents which had a safeguarding element.

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.

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

Maternity

The service was led by a director of midwifery, associated director of operations, clinical lead obstetrician and neonatal safety champion who formed a quadrumvirate. The quadrumvirate were supported through clear professional arrangements. They were supported by a maternity management team made up of an obstetric clinical lead, matron and directorate manager. The head of midwifery worked alongside the quadrumvirate and other senior leaders in the directorate.

There was a governance group which consisted of a head of maternity compliance, patient safety lead, perinatal mortality midwife, compliance lead, audit and quality lead, equality, diversity and inclusion midwife and maternity information officer.

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 matron. The executive team visited wards on a regular basis. Staff told us they saw senior maternity leaders regularly and spoke of how accessible and encouraging they were. Staff received a monthly blog from local leaders in their area to share information.

The service was supported by maternity safety champions and non-executive directors. The chief nurse was the board maternity safety champion and sat on the maternity and neonatal safety and compliance committee alongside the quadrumvirate. They worked closely with the non-executive maternity safety champion to act as conduit between the board and frontline staff and give an independent and objective view of maternity services. They took part in regular walk rounds of the service to meet staff and we saw the outcomes from these displayed on the quality and safety boards in each ward and area across the unit.

Leaders 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. The service had an aspiring band 7 pathway for midwives. This gave them protected time over a 6-month period to lead in quality improvement projects, shadow existing band 7's and develop skills to enable them to be successful in applying for band 7 positions.

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. We saw the vision and strategy displayed throughout the unit, including how this translated to the vision for each individual area.

The local Maternity and Neonatal Voices partnership (MNVP) were involved in the development of the vision and strategy for maternity services. They told us they felt their opinion was taken on board and valued in the development of the strategy. The service had held focus groups with staff and women and birthing people to develop the strategy. The vision for the service had been translated into the top 10 languages used in the area and we saw this in posters displayed around the unit.

Maternity

The maternity strategy for 2022 to 2025 was aligned to the trust clinical services strategy. It identified workstreams for quality and improvement with a lead attached to each workstream.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. There was a workstream specifically for equality and access in outcomes with an underpinning objective to 'provide an equitable service in access and outcome terms, tackling the multiple dimensions that affect local healthcare inequalities driving unwarranted variation in maternity'. From the strategy leaders had set maternity priorities for the next 12 to 18 months and had monitored progress against these.

The service had identified measures to measure the success of each workstream. Leaders and staff understood and knew how to apply them and monitor progress. For example, measures of success for equality in access and outcomes included % of women and birthing people receiving continuity of care, reduction in adjusted perinatal mortality rate and achieving baby friendly accreditation.

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 woman and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued. Staff were positive about the department and leadership team and felt able to speak to leaders about difficult issues and when things went wrong. They spoke about a 'no blame' culture in the unit where they could raise concerns and learn from incidents. Staff told us the culture had improved from previous years, with a more inclusive culture and more approachable senior leadership team.

Staff we spoke with told us there were good working relationships across the multidisciplinary team They told us there was good support for preceptor midwives and the service had a recruitment and retention midwife who also supported preceptors.

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

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. 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. For example, the service had looked at data to see if ethnicity or disadvantage had been an influence in Avoiding Term Admissions Into Neonatal units (ATAIN) audits and on breast feeding initiation rates. They had adapted guidelines, such as those for management of 3rd and 4th degree tears, to include specific guidance for women and birthing people from ethnic minority and disadvantaged groups.

The service promoted equality and diversity in daily work. Policies and guidance had an equality and diversity statement. Leaders had taken action to address issues raised by internationally qualified midwives to improve career development and retention.

Maternity

The Workforce Race Equality Standard is a set of measures which enable NHS organisations to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. For 1 WRES metric, results for staff from all other ethnic groups were better to results for white staff, a lower proportion of staff from all other ethnic groups experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months. However, a higher proportion of staff from all other ethnic groups experienced harassment, bullying or abuse from staff in the last 12 months, indicating poorer experiences for staff from all other ethnic groups.

However, WRES data is for the whole trust and not solely maternity services, so it is not possible to ascertain if poorer experience relates to maternity services. Staff did not raise such concerns during our inspection. Staff told us they worked in a fair and inclusive environment.

The results of the 2022 NHS staff survey showed the service performed better than 2021 in 67 out of 91 comparable questions. There had been a 12% improvement in terms of recommending the service as a place to work, a 10% improvement in feeling safe to speak up about concerns and a 14% improvement in belief that caring for patients was the trust's priority. Overall, there had been a 3.3% improvement in staff satisfaction across all questions.

The service had a comprehensive action plan based on the 2022 NHS staff survey results which included actions to address staff concerns about immediate line management support, experience of bullying and harassment and reasonable adjustments being made for staff with disabilities or long-term conditions.

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. We saw 9 complaints had been made to the service between August and October 2023.

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

Managers investigated complaints, identified themes and shared feedback with staff. We saw feedback from complaints was displayed on the quality and safety boards in each area.

Staff knew how to acknowledge complaints and woman and birthing people received feedback from managers after the investigation into their complaint. We saw emails sent in response to initial complaints gave clear information on how to progress the complaint through formal and informal routes.

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. Staff and leaders could clearly articulate the governance framework for the service and how information flowed between maternity services and the board.

Maternity

There was a head of maternity compliance who was supported by a compliance lead, audit and quality lead, equality, diversity and inclusion midwife and maternity information officer.

The service had a meeting structure which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues. Leaders met monthly at the urgent care board, which fed into the trust wide quality committee.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. The quadrumvirate met with executive directors at monthly performance meetings which monitored flow through the maternity department and key metrics such as maternity assessment and triage.

The maternity clinical governance group met monthly. We reviewed the minutes for September to November 2023 and saw the meetings were well attended by staff and managers across the multidisciplinary team. There was a set agenda which covered key areas including incidents, complaints, the clinical dashboard, staffing, compliance, and audit. The group identified items which required escalation to the trust board. There was a guest speaker at each meeting to update on key areas of performance such as complaints or MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries).

The quadrumvirate met weekly to look at performance reports, staffing, quality improvement initiatives, complaints, and incidents. They also reviewed the risk register each month.

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

Staff representatives were present at clinical governance meetings to disseminate information back to all staff and all staff had access to the minutes of clinical governance meetings. Information was displayed on quality and safety boards in each area, and this was updated monthly.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies we reviewed were up-to-date, readily available to staff and followed relevant national guidelines.

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 service monitored compliance with the saving babies lives care bundle version 2. We saw the service had declared compliance with implementation of all 5 elements of this.

Maternity

The Maternity Incentive Scheme (MIS) is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with 9 out of 10 safety initiatives. It could not demonstrate compliance with action 6 of the safety actions – 'Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 1. We saw the service tracked compliance with MIS and had reported progress to the board in July 2023. The report highlighted areas where compliance was not yet achieved, and actions taken to achieve compliance. Following our inspection, the service told us it declared full compliance with the scheme in December 2023.

We reviewed the service's compliance with the perinatal clinical quality surveillance model (PQSM) which was submitted to the Local Maternity and Neonatal System (LMNS) bi-monthly. We reviewed the report submitted for July to September 2023 and saw the service submitted data for all key areas including serious incidents, MNSI reports, perinatal deaths, compliance with MIS, training compliance and ATAIN.

The service provided up to date information to the national MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) survey. Between July and September 2023, there were eight perinatal deaths. All cases were reported to MBRRACE-UK.

The service recorded and reviewed perinatal deaths using the perinatal mortality review tool (PMRT). We reviewed the perinatal mortality report for July to September 2023. It showed the overall perinatal mortality rate for 2023 to 24 to date, at 4.22 per 1000 births was below the national 2021 annual mortality rate of 5.19 per 1000. Details of all cases, reviews and action plans were reported to the trust board.

The service held weekly PMRT meetings. We reviewed minutes of the last 3 PMRT meetings and saw issues relating to the care provided were identified and discussed and parental perspectives were included.

The service had an Ockenden assurance visit in September 2022 to assess compliance with the 7 immediate and essential actions from the interim Ockenden report. The service was fully compliant with 5 of the 7 immediate and essential actions and partially compliant with 2. The service had an action plan to improve compliance which was monitored and updated regularly.

During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool. The dashboard reported on clinical outcomes such as postpartum haemorrhage, 3rd and 4th degree tears, return to theatre and admissions to neonatal unit. It measured some antenatal indicators such as bookings and women and birthing people on continuity of care pathways by ethnicity.

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 service had an audit programme which aligned to key trust and national drivers. The service completed a maternal sepsis audit which tracked performance in 2019, 2021 and 2023 and developed an associated action plan.

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. For example, monthly audits during 2023 identified that achieving knife-to-skin within 75 minutes for category 2 caesarean section was a challenge. A poster was created and shared with maternity staff via the monthly newsletter and displayed in clinical areas to remind staff of the standard. Following this compliance improved and re-audits were completed, with actions developed to target areas of low performance.

There was a quality and safety board in each area which was updated monthly and clearly display key quality and performance data for staff.

The service held twice weekly cardiotocography (CTG) forums and a CTG lunch club. These were open to all staff across the multidisciplinary team and staff told us they were encouraged to attend them. Staff reviewed a sample of CTGs to assess if they were completed and escalated appropriately and to identify any learning.

Serious incidents review meetings were held monthly, and we looked at minutes for the last 3 meetings. We found they reviewed relevant incidents and immediate actions and escalated to serious incident investigations where appropriate.

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

The service had a risk register which we reviewed and saw the risks aligned with those discussed by staff and leaders during our inspection. We saw the services acted quickly to add risks to the register and identify mitigating actions when they became aware of risk. For example, during inspection we raised concerns about the security of Marsh and Iffley wards. This added to the risk register and some immediate actions taken with plans to identify longer term mitigating actions. We saw the risk register was reviewed regularly and the progress of actions monitored.

The service had a maternity risk management strategy which was underpinned by the trust risk management policy and procedure. The purpose of the strategy was to ensure that all maternity staff were aware of the process for managing risk within maternity services, how to do this and their own responsibilities in managing risk.

The service had an escalation and unit diversion protocol in place to proactively manage activity and acuity across the trust. This followed the escalation policy across the local area. All diverts were incident reported as a maternity red flag. Leaders in the service monitored diverts through their dashboard. Between April and October 2023, the unit had not been closed and no diverts requested.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could benchmark and compare to national indicators and against local targets. However, the service's dashboard did not use statistical process control (SPC) to interpret the data presented. SPC uses statistics to identify patterns and anomalies and helps to distinguish changes which need to be investigated from normal variation in data points. This meant there was a risk leaders could not clearly identify when there was a variation in data that needed to be investigated or escalated. However, leaders told us they planned to introduce SPC to display and interpret the clinical dashboard and a paper had been submitted to the maternity clinical governance meeting.

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 regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

We saw relevant incidents were reported to the National Learning and Reporting System (NRLS) and the Maternity and Newborn Safety Investigations programme (MNSI), formerly HSIB.

Engagement

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

Leaders worked with the local Maternity and Neonatal Voices Partnership (MVP) to contribute to decisions about care in maternity services. The chair of the MNVP met regularly with senior leaders and maternity safety champions and sat on several relevant groups such as compliance group, quality and safety group and the multidisciplinary education team group. They gave examples of how feedback they shared had led to changes in the service, such as work being co-produced with the MNVP to look at changes to visiting on the wards.

There were bi-monthly MNVP meetings attended by key stakeholders including staff from the service. We reviewed the minutes from the last 3 meetings and saw key performance data was shared and themes from incidents as well as plans for service development and coproduction of resources. The action log was reviewed at each meeting and any additional actions added.

The MNVP completed a ‘15 Steps’ visit and report in May 2023. Fifteen steps is a toolkit developed and published by NHS England to be used by MNVPs to support them to elevate the voices of the service users and allow them to explore collaborative working to review, explore and design services within maternity units. The feedback from this was mainly positive with good feedback about the appearance of the environment. A ’15 steps’ visit had been carried out in November 2023 and the service was waiting for this report. The MNVP told us women and birthing people had commented on changes being made following a ‘15 steps’ visit and this meant they felt their voices were heard.

During our inspection we saw notice boards on wards with information for women, birthing people and families about resources, health promotion and the MNVP. The information was clear and easy to read and there were QR codes for women and birthing people to scan and leave feedback about their care and treatment.

The service provided amenity bags in the induction of labour suite. These were bags which contained toiletries and useful items for the woman or birthing person’s stay on the suite. There was also a leaflet which explained what would happen during induction of labour and books, puzzles and games to help pass the time on the induction of labour suite.

We received 16 responses to our give feedback on care posters which were in place during the inspection. Of these responses 8 were mixed and 8 negative. Themes included mixed experience of staff, some praised staff attitude, others stated staff were dismissive and they did not feel listened to.

Maternity

The service always made available interpreting services for women and birthing people and collected data on ethnicity. They worked with local voluntary sector and public health partners on the 'seeking sanctuary' project, aimed at families who may be refugees, asylum seekers, trafficked or fleeing conflict to access maternity care. They provided outreach clinics led by midwives and obstetricians. The service reduced many of the barriers to attending maternity appointments including the provision of free transport and interpreters.

The service held an equality and diversity stakeholder event to gain feedback on access to maternity services for women and birthing people from ethnic minority groups. They had created a perinatal befriender role in partnership with the local maternity and neonatal system (LMNS) to reach out to women and birthing people in areas of higher social deprivation.

The service adapted the Practical Obstetric Multi-Professional Training (PrOMPT) training to include training to address health inequalities. For example, they included recognising deterioration in different skin colour and tone and had resuscitation dummies available in different skin colours. They provided culture in health training to senior midwives which focused on skills and knowledge that value diversity, understand and respond to cultural differences.

Leaders understood the needs of the local population. From August 2023, the service audited the number of women not achieving their birthplace choice and monitored this through the clinical dashboard. Rushey midwifery led unit was suspended 15 times in August 2023, this impacted 9 women who could have birthed on the birth centre. The service planned to continue to monitor and review this to understand the impact on women and birthing people.

The service had developed a pregnancy after loss service which defined clear pathways and support for women and birthing people who experienced loss at any gestation.

Staff told they there was good communication from local leaders, who set monthly blogs via social media to all staff. The service produced and circulated newsletters to all staff in the service. We looked at the most recent 3 newsletters which included sharing learning, key performance data, changes in guidelines and staffing announcements, including thank you and congratulations.

The service held a series of staff listening events throughout 2023 targeted at specific staff groups. The service took action based on staff feedback and shared this using a 'you said, we did' approach.

The service had opened the infant feeding room to staff across the hospital who were returning from maternity leave to have a private and comfortable room to express breast milk with equipment available.

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.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service had a range of quality improvement projects in progress related to improvement identified internally and in national audits. These were monitored on a programme tracker with regular updates and progress reports.

Maternity

The service identified a number of maternity driver metric to focus quality improvement on and improve performance. These were aligned to the maternity and trust strategic direction. They used quality improvement methods to assess current performance and set targets for improvement. These were reviewed and presented in a performance report bi-monthly.

The service used patient leaders to support the clinical quality improvement programme and ensure the perspective of women and birthing people was heard. Patient leaders were volunteers in the trust who worked with the service to design and change patient services for the better.

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. Staff gave examples of quality improvement projects they had been involved in such as introducing the use of ice packs on the delivery suite for women and birthing people who experienced tears and visual aids developed to place next to beds to identify mother's where additional neonatal care was required.

Outstanding practice

We found the following areas of outstanding practice:

- On the midwifery led unit there was a 'early labour' room. This could be used by women and birthing people in early stages of labour, before they needed admission to delivery suite or a birthing room in active labour. This was especially useful for women and birthing people who experienced anxiety or who had long distances to travel.
- The service had recruited and trained maternity nurses who were band 5 nurses with additional maternity training to care for post operative women and birthing people and neonatal babies.
- The service adapted the Practical Obstetric Multi-Professional Training (PrOMPT) training to include training to address health inequalities. They used resuscitation dummies in different skin colour and tone in training to recognise deterioration in people with a range of skin colours and tones.
- The service worked with local voluntary sector and public health partners on the 'seeking sanctuary' project, aimed at families who may be refugees, asylum seekers, trafficked or fleeing conflict to access maternity care. This had been used as an example of best practice within the NHS England 3 Year Delivery Plan for Maternity and Neonatal Services.

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.

Maternity

Action the trust SHOULD take to improve:

- The service should ensure staff escalate women and birthing people and babies at risk of deterioration appropriately.
- The service should ensure all staff receive training on learning disability and autism.

Maternity

- The service should continue to improve performance to ensure women and birthing people are triaged in a timely way when arriving at maternity assessment unit.
- The service should ensure all staff receive regular medicines management training and competency assessments.
- The service should continue to review the management of recovery care to ensure this is provided by appropriately trained and competent staff.
- The service should continue to develop the dashboard to identify patterns and anomalies and ensure variation in data to be investigated or escalated is clearly identified.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 1 other CQC inspector, 2 midwifery specialist advisors and an obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.