Requires improvement

Maternity and family planning

Safe	Inadequate
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Information about the service

A full range of maternity services is provided at the Royal Berkshire Hospital, which include:

- Rushey midwifery-led unit
- Iffley ward antenatal, postnatal and transitional care
- Marsh ward postnatal
- Delivery suite
- Antenatal clinic
- Day assessment unit
- Community midwifery
- Ultrasound department
- Willow bereavement room

During 2012/13 there were 5833 hospital deliveries and 5939 births (includes mutiple births) at the Royal Berkshire Hospital plus and 143 home births.

The delivery suite comprises ten delivery rooms, a room with a birthing pool, and another room used for delivering known as the 'home from home' room. There are two operating theatres, and three rooms used for women who require a higher level of care, but are not in labour. The day assessment unit is adjacent to the delivery suite, and comprises of four rooms. All inductions commence on the day assessment unit – up to a maximum of four per day. and pre-operative assessment also occurs here.

Rushey Midwifery-led unit is a labour unit comprising of four rooms and is located on the sixth floor, adjacent to the neonatal unit (NNU), Buscot ward. Triage occurs here in one of two additional rooms.

Iffley ward provides antenatal, postnatal and transitional care, and Marsh ward is a postnatal.

Community services are provided by four teams of community midwives. Satellite antenatal clinics are held once a week at both West Berkshire Community Hospital and Wokingham Hospital, and obstetric ultrasound sessions are held twice weekly at West Berkshire Community Hospital. Multi-professional antenatal clinics are held at the Royal Berkshire Hospital. A consultant who specialises in fetal medicine has twice weekly sessions within the ultrasound department.

Requires improvement

Maternity and family planning

Summary of findings

Midwifery staffing levels were found to be insufficient to provide a consistently safe service, especially on Rushey ward. However, following our announced inspection, the trust closed two beds to manage capacity and associated safety risks. Medical staffing did not meet the recommended national guidelines for consultant presence on the unit. The ventilation system within the delivery suite had been identified as not meeting standards expected, which meant that staff were potentially at risk from inhalation of excess nitrous oxide. Essential maintenance of equipment would often take some time to occur. Baths on Rushey ward were used to labour and deliver in, and evacuation equipment in the event of a sudden maternal collapse was not available in these rooms; however, the trust closed these rooms following the announced inspection, until a formal review could be carried out regarding their safety.

Instrumental and caesarean section rates were higher than expected. Inductions of labour were subject to delay due to workload pressures. The maternity service had a policy to divert women to neighbouring trusts due to lack of capacity or high workload, which was implemented at least once per month. At these times the home birth service could also be suspended.

Care was delivered with kindness and compassion. Patients and their partners were involved, and emotional support was good, particularly in times of bereavement. There was a visible and supportive midwifery and obstetric management team and there was an open and honest culture with well-defined governance structure.

Are maternity and family planning services safe?

Inadequate

Significant improvements were required in order to ensure that safe care was delivered to all women at all times.

Midwifery staffing levels were insufficient to provide a consistently safe service. In order to provide one-to-one care in labour, midwives were taken from the ward areas and the community, leaving them under-resourced for the work they had to undertake. As a result, medicines and observations were at risk of being delayed. Activity on Rushey ward far outstripped its capacity with the current midwifery staffing.

Midwives were undertaking triage whilst also carrying out the duties that should be done by the ward clerks or support workers. Women were, at times, left unobserved in waiting areas whilst midwives attempted to find them a bed on the delivery suite. Additional staffing had been recommended following both internal and external reviews undertaken as a result of a cluster of deliveries, where babies were born in an unexpectedly poor condition. In addition, it was recommended that a band 7 midwife be in charge on each shift. This had yet to be put into action, despite the cluster of incidents occurring eight to nine months ago.

During our inspection we were sufficiently concerned about the staffing levels that we raised this with the executive team. They immediately responded to our concerns and closed two of the beds on Rushey Ward within 24 hours.

Cleanliness, Infection control and hygiene

- Ward areas appeared clean, and we saw staff regularly wash their hands and use hand gel between treating patients.
- 'Bare below the elbow' policies were adhered to. Hand gel dispensers were outside all doors, with signage advising staff and visitors to use it.
- There were no recent cases of MRSA and C. difficile.

Maternity and family planning

Midwifery Staffing

- Births to midwife ratio was 1:35 across the organisation; however, the midwife to birth ratio on Rushey ward was considerably higher, and at times it had been reported as 1:62 due to increased deliveries on Rushey ward.
- Staff were called from other areas to provide one-to-one care for labouring women, which was achieved between 98-100% of the time. In addition to this, 10.2 wte midwives had recently been appointed, but were yet to commence employment. There was an additional vacancy rate of 1.2 wte.
- Following an external review, commissioned as a result of a cluster of deliveries with babies born in poor condition, it was identified that an additional six midwives were required on Rushey ward. The incidents had occurred eight to nine months ago. The external review reported their findings in January 2014. A business case had been agreed by the Urgent Care Board to recruit additional midwives; however, this was yet to be approved by the trust and the staffing shortfall remained at the time of the inspection.
- The external review identified the need for a band 7 midwife to be in charge and co-ordinating for all shifts on Rushey ward. This was still not in place for all shifts. Midwives worked twelve hour shifts, which meant there were a total of 14 shifts in a week. Only five of the 14 shifts per week were covered by a band 7 midwife from the core of midwives who were on Rushey staffing rota. The other band 7 cover was provided with staff movement throughout the unit to attempt to address this, but there were still occasions when the ward was without a senior midwife.
- The co-ordinator on the delivery suite was supernumerary for most of the time. The delivery suite undertook an activity monitoring tool, as recommended by the National Patient Safety Agency. Activity was recorded every four hours. This showed that the co-ordinator for the delivery suite was supernumerary for 86-96% of the time.
- Staff reported that most newly-recruited midwives were newly-qualified, and therefore employed to undertake preceptorship scheme work before progressing onto a band 6. Whilst accepting this was necessary, staff told us that this added greater pressure to existing and experienced midwives, who were required to support the new midwives in practice.
- Rushey ward staffing levels allowed for two midwives to care for labouring women, one midwife to undertake triage, and one midwifery care assistant. At night, the homebirth midwife and their second (community-based) midwife also attended the unit, if they had no women at home in labour, who were planning a home birth.
- As there was no ward clerk employed for any cover on Rushey ward, the triage midwife also undertook roles that would often be undertaken by them; for example, accessing medical records. Most women attended the triage area before being transferred to other areas, such as the delivery suite or to Iffley ward if appropriate. We saw, at times, there was more than one woman attending who was requiring triaging. We reviewed the activity of one night picked at random, and saw three women had attended in labour, one at 3.05am, one at 3.10am and one at 3.20am. These were all under the care of the triage midwife as there were also two women in labour. The triage midwife was required to keep a log of activity. We reviewed the log which contained large gaps. We were told this was as a result of the triage midwife being too busy to complete the paper log. This meant there was not a clear record of activity, particularly when the Rushey unit became busy.
- During busy times, in order to achieve one-to-one care in labour, midwives were taken from other areas, such as Iffley ward and Marsh ward. Staff there told us that this was a frequent occurrence. We saw from incident reports that at these times, care was often sub-optimal, with delay in the administration of medicines and observations.
- Iffley ward presented their ideal and actual staffing numbers on a safety cross on the ward, and also as a percentage. The agreed midwifery staffing numbers for the ward were set at four midwives on an early shift, four on a late shift, and three on a night shift, supported by one nursery nurse per shift and two midwifery care assistants. Figures for January 2014 showed they only had the correct number of midwives on an early shift for 19% of the time, for a late shift that figure fell to 6%, and for a night shift, 13%. Nursery nurse and midwifery care assistant presence ranged from 90-100%. We saw, at busy times or during periods of sickness, areas were left with insufficient staff. For example, we saw one incident report from Iffley ward in October 2013, which reported a full ward with two midwives, one staff nurse and one maternity care assistant. Agreed staffing levels were for

four midwives. The incident report stated inadequate care was given. No support was given to breastfeeding and first time mothers. There were a total of 19 discharges, five babies were in receipt of IV antibiotics, one baby was receiving phototherapy, and a postnatal mother required a blood transfusion. There were also delays in administering intra venous antibiotics.

- An incident report from October 2013 cited that only one midwife and two maternity care assistants were on Iffley ward for a night shift. On another night, Iffley ward had 14 antenatal women, including two who were being induced, one in early labour awaiting transfer to the delivery suite for artificial rupture of membranes, 11 postnatal women and babies, of which five babies were in receipt of transitional care, including one having intravenous antibiotics, and one having phototherapy. One midwife was taken to work on the delivery suite, leaving only two midwives on the ward. As a result, staff reported not having breaks, and delays had occurred with medication administration, including those prescribed to be given intravenously.

- Sickness levels were higher than other areas within the trust, at 5%, and above the England average of 4.3%. Staff told us people would often become unfit for work as a direct result of the stress they felt from the workload. Medical staff told us that they felt there were insufficient midwives, and that they had a high sickness rate as a result of the pressure they worked under.
- All midwives must have access to a Supervisor of Midwives at all times, (NMC 2004 Midwives rules and standards - Rule 12). The ratio of Supervisor of Midwives to midwives was 1:20. This is higher than the recommended ratio of 1:15 and greatly increased the workload on the Supervisor of Midwives. Supervisor of Midwives are required to carry out annual reviews with all midwives. This had occurred for 93% of the midwives.

Medical Staffing

- There were seven full time consultants obstetricians were employed. Obstetric consultant cover on the delivery suite ranged from 68-91 hours, which was below the recommended standard of 168 hours of consultant cover each week. None were employed to also cover gynaecology. However, junior staff were shared between both specialities.
- There was a requirement for dedicated anaesthetic consultant cover to be present on the delivery suite for a minimum of 50 hours a week. This was not being met on most weeks, with 46.4-47.8 hours cover being provided. However, a consultant anaesthetist was present on the delivery suite Monday-Friday 8am–6pm. Out of hours, there was always a consultant on-call. Trainees received daytime supervision by the consultant anaesthetist on the labour ward. Staff we spoke with felt that consultant anaesthetists readily attended out of hours.
- Junior doctors told us that there were adequate numbers of junior doctors on the wards out of hours, and that consultants were contactable by phone if they needed any support.
- Whilst midwifery staffing levels did not change across the week, medical staffing was reduced at weekends. Consultants were, however, on-call, and it was recognised they were always available, and that they had a low threshold to attend. However, consultants did not always routinely visit the wards frequently. This meant that some women, who were admitted antenatally, did not see a consultant during their inpatient stay.

Nursing and Medical Handover

- Midwifery handover occurred at the beginning of each shift. Medical staff undertook handovers on the delivery suite. The handover was structured and detailed issues of concern.

Management of the deteriorating patient

- The unit used the Modified Obstetric Warning Scoring System. Staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts, and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- Staff undertook ‘fresh eyes’ on the delivery suite. This is a structured review of electronic fetal monitoring by someone other than the midwife providing care, and was required to occur hourly during labour. However, this did not always occur on Rushey ward when patients needed continuous monitoring.
- Staff used the SBAR communication tool when handing over or discussing concerns (Situation, Background, Assessment, Response).
- A few staff on the delivery suite had undergone the high dependency course through the University of the West London to increase skills of HDU care.

Requires improvement

Maternity and family planning

Safety Thermometer

- Safety thermometer information was clearly displayed on the wards. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers. In addition, required and actual staffing levels were publicised on Iffley ward, along with medication incidents.

Incidents

- There had been no recent 'never events' reported. A 'cluster' of deliveries with poor neonatal outcomes were identified over a period of two months on Rushey ward. As a result, an internal investigation was undertaken. Meetings were held with staff on the ward, chaired by senior members of the midwifery team, and findings were shared with staff. Staff felt the process had been open and responsive. Learning had been identified, and action had been put in place. For example, all staff were now fully trained in the use of the resuscitaire devices on the ward, which differed from those used on the delivery suite, and simulation training occurred on Rushey ward as well as on the delivery suite.
- The results of serious untoward incidents were shared with staff through maternity governance and clinical risk meetings. Minutes were shared with staff, and learning as a result of them became part of the annual professional study day for midwives.
- Where serious incidents occurred, senior staff offered to meet with parents and share the investigation reports.
- All staff we spoke to stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at monthly clinical risk and governance meetings. Where necessary, supervisors of midwives were involved in practice and performance issues identified as a result of incidents.
- Staff reported clinical incidents such as 3rd and 4th degree tears, retained placentas, and unexpected admissions into the neonatal ward. The frequency of these were then monitored to identify trends. As a result, changes were implemented. For example, there had been an increase in perineal wound infections. Cleansing solution had been changed and staff had been reminded of the need to inspect perineums during the postnatal examination.
- Incidents relating to extreme workload, or reduced staffing levels, were inconsistently categorised. Some incidents were recorded as incidents affecting the organisation, some as incidents affecting staff, and some as incidents affecting the patient. A lack of a consistent approach to the recording of incidents where staffing levels were sub-optimal, and affecting patient care and safety, meant that an overview could not be seen and monitored.
- Staff received feedback from incidents at ward and department meetings. Minutes of ward meetings were also produced and sent to staff, as well as being placed on a shared drive.

Environment and Equipment

- The labour ward had an insufficient scavenging system to remove used nitrous oxide from the air (produced when using entonox). This was identified following an external report which identified a risk to patients and staff. This was placed on the risk register in April 2013, and was categorised as a major risk. There was no date identified at which this was to be addressed and women continued to use entonox throughout their labours as required. This meant that staff would potentially be exposed to higher than expected levels of nitrous oxide.
- Wards and the delivery suite were accessed through a locked door, controlled by a buzzer, with CCTV observation. Staff wore identification badges containing their photographs. We observed people being questioned before they were allowed entry. However, the risk register referred to a security incident in November 2013, where a back stairway giving access to a postnatal ward had been found to be unlocked. The continuous alarm had been silenced, meaning that staff were not alerted to the issue. Staff had been informed to be vigilant. A further incident occurred, and despite escalating concerns to the director of estates, a formal response remained outstanding in February 2014.
- Equipment was appropriately checked and cleaned regularly. We saw emergency resuscitation trolleys had been checked thoroughly daily, and records were maintained to demonstrate this. There was adequate equipment on the wards to ensure safe care (specifically cardiotocography (CTG) and resuscitation equipment). However, staff we spoke with identified concerns regarding maintenance and repair of essential equipment, particularly sonacaids used for listening to the fetal heart in the community, and prior to placement

of a CTG. Where these had required repair, staff reported periods of 2-3 weeks where they were required to share equipment with their colleagues. We also saw incidents reported where staff were unable to monitor all babies via a fetal scalp electrode when it was necessary. As a result, abdominal monitoring was used until 'a lead' had become available as a result of a delivery.

- Rushey ward had four delivery rooms, one of which had a birth pool and two of which had large corner baths. Midwives we spoke with described using the baths frequently when women were in labour, and also conducting the delivery of some women in them. There was one net for the emergency evacuation of a collapsed woman out of the birthing pool. This was stored in the delivery room within easy access. However, no emergency evacuation equipment existed in the rooms with corner baths. When asked how evacuation would be conducted should a woman collapse in the bath, staff told us they would use a sheet and had practised with this. This potentially placed the health and safety of both women and midwives at risk. This was raised with the executive team during the announced inspection, and they closed the two rooms on Rushey ward to prevent these rooms being used for women to labour in the bath, until the risks and mitigations had been assessed more thoroughly.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Staff who administered IV antibiotics to neonates received additional training.

- The midwives exemption list meant midwives were able to administer medicines such as diamorphine and entonox to women in labour.
- Emergency O negative blood and a paediatric blood supply were stored in a blood fridge on the delivery suite. A Bar coded system was in operation for tracking and monitoring usage. Stock and storage was the responsibility of the transfusion department.

Records

- All records were in paper format and all health care professionals documented in the same place. Women were given hand held records at booking. These were added to at each visit to a healthcare professional.
- Care pathways for first stage and second stage of labour were used in all areas.
- Postnatal records were created following delivery, containing all details of the mother and baby, including mode of delivery, blood loss and the neonatal check. These records accompanied the woman on discharge and were used by the community midwife during all home visits. On discharge from the service, these records were returned and 'married up' with the woman's medical records.
- All midwives and doctors had a stamp of their name and registration number. This made it clear who had made each entry.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- Patients were consented appropriately and correctly. At the time of the inspection, there were no women who did not have capacity to consent to their procedure.

Mandatory Training

- We looked at staff mandatory training records, and compliance with mandatory training was good.
- Staff stated that they had good access to training and received four mandatory training days per year, covering obstetric emergency skills training, neonatal and adult resuscitation, and a professional day which covered any new and 'hot topics'.
- Midwives were also required to undertake CTG training every three months.
- Compliance with training was good, and was linked to incremental pay progression.
- Midwives who were newly-qualified undertook a period of preceptorship, which lasted at least nine months. During that time they were able to attend monthly supervision sessions. They were also required to complete all mandatory training and to be assessed as competent for skills such as cannulation and perineal suturing. Newly qualified midwives spoke highly of the support and access to training they received during this time.
- Data received from the trust showed compliance with mandatory training to be significantly lower than that evidence of compliance being reported by the service areas.

Requires improvement

Maternity and family planning

Are maternity and family planning services effective?

(for example, treatment is effective)

Requires improvement

The maternity service required improvement in order to be effective. Guidelines were written in line with national guidance, and policies and procedures were updated as practice changed. New learning was fed into the midwifery professional learning days.

The service had a dashboard, but few staff beyond senior staff were aware of it. Instrumental and caesarean section rates were higher than expected; this not only increases the costs to the service, but also the risk to women and babies. Inductions of labour were subject to delay due to workload pressures. In one month postponement of planned inductions occurred 72 times. The home birth service had, on at least two occasions, been suspended. The homebirth rate was below the Clinical Commissioning Group (CCG) target but on a trajectory to meet it.

Staff worked well together, and there was a well-resourced multidisciplinary team, meaning that the requirements of women with medical or complex health or social needs were met. Communication was felt to be good. This meant that women in greatest need received the care and support they required to meet their needs.

Failure to maintain and repair equipment in a timely manner meant that the service was unable to run effectively at times.

All forms of pain relief were available to women, including a 24 hour, seven day a week epidural service.

Use of National Guidelines

- The Maternity unit used nationally-recognised guidelines (for example, Safer Childbirth: minimum standards for the organisation and delivery of care in labour) to determine the treatment they provided. Local policies were written in line with this, and were updated if national guidance changed.
- At the monthly departmental meetings any changes to guidance, and the impact that it would have on their practice, were discussed. Changes also featured in the annual professional day. In addition, the delivery suite had a board where a ‘Topic of the month’ was available for all to read.

Outcomes for the unit

- The maternity service had a quality dashboard which was reviewed monthly at the governance meeting; however, junior medical staff were unaware of its existence.
- The normal delivery rate (58%) was below the England average (61%).
- The elective caesarean section rate at 11.8% was higher than the England average (10.7%). The emergency caesarean section rate was comparable with the England average (14.8% against an England average rate of 14.5%). When questioned, one member of staff indicated that there was a pressure to carry out caesarean sections for non-clinical reasons, due to the ward pressures.
- Instrumental delivery rates overall were also higher than the England average (14.5% compared to 12.7%). When questioned, medical staff spoke of the difficulty in supervising all deliveries to support decisions and modes of delivery.
- Puerperal sepsis and other puerperal infections were higher at 149 for the period July 2012-July 2013, than would be expected at 124. Staff told us that midwives had been reminded of the need to view perineal and abdominal wounds for signs of healing during the postnatal examination.
- 22-23% of all deliveries occurred on the midwifery led unit (Rushey ward). Rushey ward also had a transfer rate in labour to the delivery suite of 28%. Of these, 28% were for delay in the second stage of labour, exceeding the national birth place study findings which reported a 16% rate for transfer due to second stage delay. Staff had identified their transfer rate as being high, and were undertaking a retrospective audit. Early findings indicated misdiagnosis of the second stage of labour as being a factor in some of the transfers. However, concerns were also raised by some staff that transfer to the delivery suite did not occur soon enough in some cases.
- The unit homebirth rate was currently 2.4%, against a target set by the Clinical Commissioning Group of 5%.

- Vaginal birth after caesarean section (VBAC) rate was 72%, against the CCG target of 60%, which meant that more women achieved a VBAC.

Care Plans and Pathway

- A Female Genital Mutilation (FGM) pathway, led by the social inclusion midwife, had been developed.
- Women who had undergone a previous caesarean section were seen in the early stages of their pregnancy, in a clinic staffed by midwives, to allow time to discuss options and modes of delivery.
- Where elective sections were planned, women attended pre-operative assessment in the day assessment unit.
- Plans of care were written with clear instructions when women were admitted antenatally, or experienced complications, such as major obstetric haemorrhage post delivery.
- There were two separate partograms for the 1st and 2nd stages of labour. These were charts used to monitor progress and record observations in labour. Each gave guidance as to normal progress. We saw these had been used in the care records reviewed, with the exception of one. In this instance, delivery occurred within five minutes of the woman entering the delivery room.

Multidisciplinary Team working and working with others

- Relationship with pharmacists, physiotherapists, neonatologists, anaesthetists and other members of the multidisciplinary team was described as very good.
- The service employed two diabetic specialist midwives, one antenatal screening co-ordinator, one newborn screening co-ordinator, one substance misuse midwife, and one HIV specialist midwife, who all worked within the antenatal clinic.
- A community diabetologist worked alongside the obstetric team, providing care for women with diabetes and gestational diabetes, and there was an anaesthetic clinic for women identified as high risk, to plan their needs for labour and delivery.
- The community team and Rushey ward were managed by the same matron. Both areas worked the same shift patterns, and midwives from the community often worked on Rushey ward.
- The midwife-led unit and delivery suite used the same policies and procedures ensuring a continuity of care.
- Iffley ward had the facility to provide transitional care to babies. This included the administration of intravenous antibiotics on the ward. There was good communication between both areas, and the nurse practitioner from the neonatal unit had provided education and support to midwives when they began to administer intravenous antibiotics. This resulted in a better experience for women, as it meant that they could remain on the ward, rather than having to attend Buscot ward twice a day.
- Midwives were trained to undertake the newborn and infant physical examination (NIPE); however, support was always available for the neonatal medical staff.
- The HIV specialist midwife attended monthly multidisciplinary meetings with staff from the department of sexual health, to plan the care for this group of women.
- At the time of the unannounced inspection, the bleep system throughout the unit had failed. Staff were using walkie talkies and mobile phones to communicate in line with the bleep policy. The issue was quickly rectified. The senior midwife in charge of the unit that day ensured that all staff were aware of how to contact each other in the envent of an emergency.

Pain relief

- Entonox, TENS (transcutaneous electrical nerve stimulation) and diamorphine were available for analgesia in labour, as was water in the birth pool on Rushey ward. Rushey ward also provide intradermal sterile water injections as pain relief for women in labour who were experiencing back pain. Though not yet recognised by NICE, as a result of the success of this trial, the practice was just commencing on the delivery suite, though at the time of the inspection, few midwives had undertaken the addition training required.
- Epidurals are available 24/7, with a dedicated anaesthetist who was based on the delivery suite

Seven day services

- Midwifery staff across the unit were unchanged during the week. At weekends, obstetric and anaesthetic consultants were on-call and available for advice as required. Obstetric Consultant presence did not meet national recommendations of 168 hours per week. Staff reported that they had a low threshold for attending the delivery suite out of hours.

Requires improvement

Maternity and family planning

Are maternity and family planning services caring?

Good

The maternity services were caring. Care was delivered with kindness and compassion. Patients and their partners were involved, and emotional support was good, particularly in times of bereavement.

Compassionate Care

- In the CQC Maternity service survey 2013, 196 women were asked about their care at the hospital. There was a poor response rate; however, from the responses seen, the trust compared about the same as other trusts for all aspects of maternity care, including antenatal, during labour and birth, and in the first few weeks after birth.
- The Friends and Family Test was being carried out, with 75% of respondents being happy to recommend the service to their friends and family. The response rate was currently 13.5%.
- Throughout our inspection, we witnessed women being treated with compassion, dignity and respect. We saw that call bells were, in the main, answered promptly.
- We looked at patient records and found that they were completed sensitively and detailed discussions that had taken place with women and their partners.
- The unit held a bereavement service each year to allow families and staff to spend time and reflect.

Patient involvement in their care

- Women we spoke with stated that they had been involved in decisions regarding their choice of birth location, and were informed of the risks and benefits of each. They felt that once they had made the decision, they had been appropriately supported.
- Women carried their own records throughout their pregnancy and postnatal period of care. These contained information as well as contact point details, and were used by all staff to document care.
- The maternity services liaison committee met quarterly, and regularly sought the views of women. This was carried out by the chair of the group visiting the wards and talking to women.

Emotional Support

- The trust employed a specialist bereavement midwife, who provided support to parents and staff alike. There was a bereavement room on the delivery suite, and a room on Iffley ward which was used for antenatal and postnatal stays.
- In the event of a stillbirth, or unexpected death, women either remained in Willow room, the dedicated bereavement room on the delivery suite, or else they returned to Iffley ward to a ‘home from home’ bereavement room, away from the postnatal areas.
- Written information was available for women in the room, allowing them to look at and take in information in their own time. We saw a diary used by women to write their experiences. Partners were encouraged to stay as long as required.
- Chaplaincy care was available. Support for other faiths was arranged as required.
- Whilst acknowledging the role was, at times, difficult and stressful, midwives and medical staff spoke of good team work, support and of enjoying coming to work.

Are maternity and family planning services responsive to people’s needs?
(for example, to feedback?)

Requires improvement

The maternity service is not responsive to the needs of the population and requires improvement.

There was good access for women to the service. Vulnerable women were particularly well supported by the Poppy team. This meant they were more likely to access the right care and attention.

Rushey ward had a good range of equipment; however, there was far less equipment available on the delivery suite. This limited womens choices with regards to positions for labour and delivery.

The maternity service had a divert policy, which was implemented at least once per month, often due to a lack of capacity or high workload. This meant that women had to travel to neighbouring organisations in order to deliver their babies. At these times, the home birth service could also be suspended, again removing womens choice. Most

women attended for triage through Rushey ward. In addition, the ward performed 23% of deliveries in only four delivery rooms. This meant throughput was consistently high. Women were, at times, required to wait in the waiting area whilst a bed was sought, particularly if a third women attended for triage, as there was only two rooms. This meant labouring women were at times unsupervised. We saw this had occurred for one women during the period of our inspection. The woman had progressed to full dilatation whilst in the waiting area.

Access

- We reviewed the incident forms and spoke to staff about the frequency that women were diverted to other units. From the incident forms viewed, we saw that the unit went onto divert at least once a month.
- Since opening 18 months ago, Rushey ward had not closed to admissions.
- The home birth service had been cancelled on at least two occasions in the last six months due to there being insufficient staff, and the unit went onto divert at least once per month. This meant women who were telephone the unit in labour were diverted to other units in the area for care and delivery.
- Performance data taken from 2012/13 showed that 89% of women were booked (attend their first appointment in their pregnancy) before 13 weeks gestation against a target of 90%.
- In the six months prior to the inspection, planned inductions of labour were postponed from between 23 and 72 times per month, due to a lack of staffing, or unit capacity issues.
- Partners were encouraged to visit, and visiting times were waived for mothers in labour. Overnight facilities were available for partners in the event of a stillbirth or neonatal death.
- A VBAC clinic was just about to commence in order to allow women access to information on the mode of delivery choices earlier in their pregnancy.

Equipment and facilities

- There was a good range of equipment on Rushey ward for women to use in labour, including birthing balls, birthing couches, mats and a birthing pool. Beds were housed in the walls, but could be pulled down when required. Should suturing be required, Rushey ward had a suturing bed to allow examination and suturing to occur. There was a couch for transfers to the delivery suite, and an additional resuscitaire device, should a delivery occur in the triage area.
- Women delivering on the delivery suite had less equipment available. The birthing pool was out of use due to a maintenance issue. There were no birthing couches, and we did not see any birthing balls during our visit. Rooms were laid out with a bed in the middle, meaning there was also less space for the labouring woman to mobilise. Each room had a chair for the use of partners during the labour.
- Birth partners were encouraged to stay with the woman when in labour; however, unless the woman had a stillbirth, facilities did not exist for partners to remain for a prolonged period after delivery. If women had a single room then partners were able to stay.
- When facilities or equipment became faulty, repair or replacement was often delayed. Staff told us that water had not been hot for several weeks during the winter period. This meant that women were unable to have a bath or shower during their stay. Other staff spoke of having to share vital equipment, such as sonacaids, whilst theirs were being repaired.

Maintaining flow through the department and discharge planning

- Midwives had been trained to perform the neonatal examination, and 99% of babies had received their newborn and infant physical examination (NIPE) within 72 hours.
- The day assessment unit is open Monday to Friday 7.30am-6pm, and Saturday mornings. Women with both antenatal and postnatal problems are assessed and treated in this area.
- Midwives told us that discharge was often delayed due to waiting for medicines to arrive from the pharmacy.
- During busy times, staff told us they ‘pulled staff’ from other areas to provide support. The main need for midwifery support was to enable one-to-one midwifery care for women in labour. This often meant midwives were taken from the postnatal wards, which in turn resulted in delays in performing discharge checks and discharging women.
- Whilst only having four delivery rooms, Rushey ward undertook 23% of all deliveries. Throughput in this area was consistently high. Staff told us that despite having four rooms, the original intention had been to only use

two rooms; however, staff did not want to turn women away and transfer them to the delivery suite if there was a vacant room on Rushey ward. The unit had a policy entitled 'planning place of birth' which set out the criteria for women to deliver either at home or on Rushey ward. This criterion included the need to be at between 37-42 weeks gestation. We spoke to one woman and her partner who had delivered on Rushey ward at 36 weeks. We also read their notes, which reported the 'unit currently full'. The woman spent one hour in the lounge / waiting area on Rushey ward, before being transferred to a delivery room. During that time, she reported feeling nauseous, and was contracting 1-2:10 (1-2 contractions every ten minutes). This was the fourth time she had presented to the unit. During that time, she had not been observed by a midwife.

- We met one woman who had delivered early that morning. We were told the staff were busy on Rushey ward, and that following triage, she had requested an epidural. Despite it being her second baby, and being in an advanced stage of labour, she was moved out of a triage room into a waiting area, where she rapidly progressed in labour. Rapid transfer to a delivery room on Rushey occurred, and she quickly progressed to have a normal delivery. Both mother and baby were well; however, immediate transfer to a delivery room from triage should have occurred. At the time, all other midwives on Rushey were with other labouring women.
- In reviewing incidents, we noted that the homebirth service had been suspended on two occasions due to a lack of midwives.

Meeting the needs of all people

- There was a team of midwives (known as the Poppy team) who looked after vulnerable and hard to access women in the community, including pregnant teenagers, and those with drug and alcohol misuse. Staff spoke highly of the team, citing good communication from them, to allow hospital midwives to provide appropriate care to meet the woman's needs. This team worked closely with social services, and other members of the multidisciplinary team.
- Women attended Rushey ward to be triaged prior to admission or delivery. We saw a 'green spot' notice had been placed on the back of the toilet doors, with the instruction to women to place a green spot sticker on the base of their urine sample pot to indicate they would like to discuss something with a midwife in confidence.
- Translation facilities were felt to be good. Iffley ward had a welcome sign written in several different languages. The service employed several midwives who were Polish, as well as some asian speaking midwifery care assistants, who worked in the community. A translation line could be used, and translators could be booked to attend with women if necessary.
- Antenatal education sessions were run for women whose main language was Polish. Polish speaking midwives ran these sessions, which covered antenatal care, place of birth, analgesia and postnatal care.
- There were several information leaflets available in the main languages spoken in the community; however, it was recognised that the views of women whose first language was not English were not always sought.

Communication with GPs, other providers and other departments within the trust

- Upon discharge from the maternity unit, antenatal women were given back their hand held records, and postnatal women were given a set of postnatal records. Both detailed what had happened during their inpatient stay, and both contained clear instructions on how to access help and support from their community midwives. A discharge summary was sent to the GP by post on discharge from the department. This detailed the reason for admission, any investigation results and treatment undertaken, and postnatal information.
- The child health record (red book) was given out to new mothers on the delivery suite.
- Postnatal care continued in the community. Postnatal records contained details of both mother and baby.

Complaints handling (for this service) and learning from feedback

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift co-ordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint.

Requires improvement

Maternity and family planning

- The matron for the maternity unit received all of the complaints relevant for her unit. She would then speak directly with the staff members involved and formulate a response. Complaints were reported on and monitored through the governance meetings, and were shared at ward and team meetings. We saw how practice had changed as a result of a complaint. Babies on the postnatal ward in receipt of intravenous antibiotics used to be taken to Buscot ward to receive their medication. As a result of the complaint, paediatric staff had worked with the maternity service to enable the drugs to be administered on the ward by midwives who had received additional training to undertake the role.

Are maternity and family planning services well-led?

Requires improvement

Staff spoke of a visible and supportive midwifery and obstetric management team. Staff were encouraged to incident report, and there was felt to be an open and honest culture, meaning staff could raise issues and report incidents without fear of blame.

There was a well-defined and organised governance structure within the unit; however, issues identified and raised were not always addressed; for example, staffing and skill mix concerns. The maternity services reported into the Urgent Care board; however, their concerns did not appear to progress beyond this as the networks appeared to work in 'silos'. This meant that serious risks, such as the ventilation system on the delivery suite, and staffing and skill mix, were not resolved. Few staff we spoke with told us of ongoing audits or audit involvement, indicating this was not part of the day-to-day running of the service.

Leadership of service

- Staff spoke of a visible senior midwifery and obstetric team. They knew who led the service, and felt the service was promoted well within the trust by them.
- Most senior nurses were aware of the leadership structure above the Urgent Care Network; however, this was less well known amongst more junior staff.

Culture within the service

- Staff were aware of the whistleblowing policy, and were encouraged to raise any concerns they may have. One staff member told us "nothing is brushed under the carpet here".
- Staff worked well together and there was obvious respect between, not only the specialities, but across disciplines.
- Staff within the directorate spoke positively about the service they provided for patients. Staff were very proud of the Rushey ward and the amount of uptake it had generated.

Governance and measurement of quality

- The maternity service had a risk management strategy which fed into the trust risk management strategy, and detailed how risk was managed with the service.
- Monthly maternity governance meetings were held. This meeting reported directly onto the Urgent Care group governance meeting. The following meetings were also held across the service which reported into the maternity governance meeting: the maternity clinical risk meeting, maternity audit meeting, perinatal mortality and morbidity meeting, midwifery service committee, maternity patient information group, maternity services liaison committee and the Supervisors of Midwives meetings. A quality dashboard was presented at each maternity governance meeting; however, when asked, most staff were unaware of its existence.
- Staffing levels were below that recommended by both an internal and an external review, several months after issues were identified. Risks categorised as red (serious risk) were also on the risk register for up to a year; for example, the ineffective scavenging system for the removal of nitrous oxide from the air. These concerns were raised through the departmental governance system, but appeared to stall once reaching the Urgent Care board meeting.
- There was a view that the directorate care groups did not work in collaboration, with 'silo' working being described, which was not conducive to shared visions or learning. Staff in the maternity service were unaware of incidents, or complaints and learning that could have been identified in other parts of the hospital.

Requires improvement

Maternity and family planning

Innovation, learning and improvement

- The delivery suite had a notice board entitled 'Topic of the month'. At the time of the inspection, the topic of the month was the use of sterile water injections for the relief of back pain in labour. This had been trialled on Rushey ward, and was felt to be a success. As a result, the practice was just about to be rolled out onto the delivery suite. Previous topics of the month had included water births. The topic of the month for April was planned to be anti-D administration. All staff were encouraged to be involved in this.
- The consultant midwife had weekly clinics to discuss mode of delivery for women who had previously delivered by caesarean section, or were requesting a caesarean section after a previous traumatic birth. This was also to include women having their first babies', who were requesting an elective caesarean section, in an attempt to address their concerns.
- Breastfeeding clinics were held Monday to Friday within the maternity unit. The unit employed infant feeding co-ordinators, who supported breastfeeding and ran the clinics. The clinics were well attended, with between six and eight women attending per day. This clinic was available for women for six weeks after delivery. Marsh ward hosted 'tele time' twice daily at 11am and 4pm, during which women and their partners could watch two short programmes: 'About breastfeeding' and 'About formula feeding'.
- A service to assess and treat babies with tongue tie was run within the breastfeeding clinic. Specially trained midwives were available to assess and perform frenulotomy.