Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Inspection report

Charles Hastings Way
Worcester
WR5 1DD
Tel: 01562513240
www.worcsacute.nhs.uk

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Ratings

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

Our findings

Overall summary of services at Worcestershire Royal Hospital

Requires Improvement 

Pages 1 and 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 Worcestershire Royal Hospital.

We inspected the maternity service at Worcestershire Royal Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level. We did not inspect services at the Alexandra Hospital as services provided at this location were outside of the scope of the national maternity inspection programme.

Worcestershire Royal Hospital provides maternity services to the population of 580,000.

Maternity services include an early pregnancy unit, outpatient department, maternity assessment unit, antenatal ward, delivery suite / labour ward, midwifery led birthing centre (The Meadow Birth Centre), two maternity theatres, postnatal ward, High dependency area / enhanced care. Between April 2021 and March 2022 4,785 babies were born at Worcestershire Royal 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 Good for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement and well-led as Good.

Worcestershire Royal Hospital is rated Requires Improvement.

How we carried out the inspection

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

We visited Maternity assessment (Triage), day assessment unit, Labour ward / Delivery Suite, maternity theatres, the antenatal and postnatal wards.

We spoke with 2 obstetric consultants, 15 midwives, 1 support workers. We received 709 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 6 patient care records, 6 Observation and escalation charts and 10 medicines records.

Our findings

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 improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff, however Not all staff were up to date with mandatory training in key skills. Not all medical staff had completed multidisciplinary obstetric emergency training, staff had not kept up to date with pool evacuation training.
- Not all staff had completed training on how to recognise and report abuse and they knew how to apply it.
- The service did not always have 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.
- Emergency trolleys and its equipment were shared between seven separate areas.
- Staff did not always fully complete and update risk assessments reducing their ability to identify risks at the earliest instance and take action. Telephone triage had one phone line with no answer message or call handling system, this meant that women were not always able to speak with the service when needed. The service experienced some issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The local audit programme, did not always collect the data leaders required in order to make fully informed decisions, making it difficult to identify and understand and manage the priorities and issues the service faced.
- Cleaning records had not been consistently completed.

However:

- 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.
- Leaders and teams had systems in place to identify and escalate relevant risks and issues, manage performance, and produce, action plans to reduce their impact. Although the service had not achieved full compliance with national incentive schemes, they had detailed action plans in place and were making steady progress.
- Most staff felt respected, supported, and valued. There were mixed trends in feedback from women and birthing people who reported they were and were not treated with kindness or respect when receiving care and treatment or during other interactions with staff.
- 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.

Is the service safe?

Requires Improvement → ←

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

Mandatory training

Maternity

The service provided mandatory training in key skills to all staff, however not all staff were up to date with mandatory training in key sills. Not all medical staff had completed multidisciplinary obstetric emergency training. Staff had not kept up to date with pool evacuation training.

Evidence of pool evacuation training was sent by the trust with the last training date in November 2021 as part of a bespoke training plan where the trust reported 100% compliance, however staff were unable to articulate how to safely evacuate women and birthing people from the pool in the event of an emergency. Following the inspection, the trust temporarily paused pool births in order to ensure 75% of core staff had the skills and knowledge to safely evacuate a woman or birthing person from the pool. Leaders told us 152 staff had undertaken pool training between 16 and 19 October 2023 enabling pool deliveries to re-open safely.

Staff were required to complete the trusts mandatory training programme to ensure staff had the skills and experience to enable them to deliver good quality care, however staff did not always complete it.

Midwifery staff received and kept up to date with their mandatory training. Eighty-five per cent of staff had completed all 17 mandatory training courses against a trust target of 90%.

Medical staff were not up to date with their mandatory training. Records showed that 69% of medical staff had completed all the required mandatory courses against the trust target of 90%. In addition to shortages in staffing, doctors strikes and sickness the trust reported that the service had recently a new rotation of medical staff into the unit in August 2023 which had impacted on overall compliance falling from 88% compliance.

Staff were required to complete professional obstetric multidisciplinary training (PrOMPT) training once a year. As of September 2023, 56% of obstetricians, 46% anaesthetists, 91% of midwives, and 78% of maternity support workers were compliant with yearly PrOMPT training. This meant the service could not be assured staff had the appropriate skills to keep women safe.

Records in September 2023 showed 89% of midwives and 82% obstetricians had completed cardiotocograph (CTG) training. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Weekly CTG meetings had been recently set up in August 2023 with the trust reporting good attendance from all staff. Ninety one percent of midwives had completed neonatal life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

Not all staff had completed training on how to recognise and report abuse. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.

Staff had not always kept up to date with training specific to their role on how to recognise and report abuse. Training records from September 2023 showed that 85% of midwifery staff and 100% of medical staff had completed Level 3 safeguarding children. Compliance for level 3 safeguarding adults was submitted in all maternity staff (midwives and medical staff) and showed that 56% had completed safeguarding adults' level 3 at the level for their role as set out in the trust's policy and in the intercollegiate guidelines (2018). This meant the trust could not be assured staff had the appropriate skills to safeguard vulnerable adults.

However, staff we spoke with could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff could identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them, lateral checks would be made, and information could be shared via the Child Protection Information System (CPIS). Staff asked women and birthing people about domestic abuse. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff we spoke with could explain safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained how ward areas were secure, babies wore electronic alarm tags and that doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection. Staff discussed the results following the drill in order to reiterate the importance of baby tagging and responding immediately to alarms.

Cleanliness, infection control and hygiene

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. However, cleaning records had not been consistently completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last 3 months compliance was consistently above 96%.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards were furnished to the latest national standards. However, during the inspection, we found gaps in bed space cleaning records and weekly and daily cleaning schedules on both post-natal and antenatal wards.

Staff cleaned equipment after contact with women and birthing people. While there were gaps in cleaning records the physical environment was clean, and we observed consistent use of the “I am clean stickers” which are used to identify when equipment was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises kept people safe. Staff were trained to use them. However, we were concerned emergency equipment was shared between a number of separate areas.

Staff carried out daily safety checks of specialist equipment. Records showed that maternity resuscitation equipment was checked daily. From August to October 2023 resuscitaires checklist audits showed staff checked 100% of resuscitaires at every shift against a trust target of 100%. Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Maternity

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. However, the triage waiting area had limited visibility of women and birthing people by staff, following the inspection the service started a system of 15 minutes observations to ensure women and birthing people are safely monitored whilst they wait.

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

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

During the inspection we saw 1 emergency trolley was shared between the midwifery led unit, antenatal ward, maternity triage, and gynaecology and 1 emergency trolley was shared between labour ward, antenatal clinic, and day assessment unit. This increased the risk for potential delays should 2 emergencies occur simultaneously where women or birthing people or their families required immediate emergency intervention. Following the inspection, the trust provided evidence additional emergency equipment had been ordered to be made available to the maternity unit.

The service had enough portable ultrasound scanners, cardiotocograph machines and observation monitoring equipment to help them to safely care for women and birthing people and babies. The service kept an up to date electronic service record of its equipment, the record showed that 205/211 had been serviced within the last 2 years and that 172/211 items had been serviced within the last year.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly, one sharps bin was found to be over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always fully complete and update risk assessments reducing their ability to identify risks at the earliest instance and take action. Telephone triage had one phone line with no answer message or call handling system, this meant that women were not always able to speak with the service when needed. However, information was shared between staff in a clear way.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage.

Leaders monitored waiting times with the aim to ensure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. However, we reviewed the maternity triage waiting times triage report between August 2023 and October 2023, we saw medical review times were not routinely entered onto the electronic patient record. This meant leaders could not be assured women and birthing people had been seen by a doctor within the target timeframe. Leaders we spoke with told us they were aware of this issue and had plans in place to make the medical review times a mandatory field within the electronic notes system. The report was able to evidence 82.6% of women and birthing people were seen for their initial assessment within the trust target of 15 minutes.

Additionally, there was no dedicated call handling system or answerphone message for the triage telephone. The trust had plans in place to implement a call handling system, however, following inspection feedback the trust reached out to

women and birthing people through push notifications and their website in order to ensure women remained safe if they were unable to speak with anyone over the phone. Additionally, the trust provided evidence of progress towards the acquisition of an additional extension lines to the current maternity triage areas, so calls made by women are not missed.

Staff used a locally named but nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used a locally adapted tool based on national tools called the Worcestershire Obstetric Warning Score (WOWS) for women and birthing people. We reviewed 6 WOWS records, and found 5 out of 6 were not complete, this meant by not completing a full set of observations for each entry the risk assessment could not accurately identify a deterioration in a person's condition. The services own audit did not identify that records were incomplete nor if they had been escalated where appropriate. Audits for July, August and September 2023 scored an average of 93% overall with 28/30 sets of notes showing complete sets of observations were taken at each instance. Additionally the trust had reviewed an audit in May 2023 and had identified women's respirations were not always completed as part of the observations leading to risk that an incomplete scoring system can mean care is not escalated appropriately.

Theatre staff regularly completed a World Health Organisation (WHO) surgical safety checklist audit which was used to reduce risk of errors during surgical procedures. During the inspection we observed parts of the checklist were not completed correctly, in particular patients were not asked their name but instead were confirmed to be the patient which removes the opportunity for the patient to correct staff if they are wrong. Additionally at the end of the procedure staff confirmed all items used during the procedure were accounted for whilst still carrying out parts of the procedure. We saw audits had not been completed in every month due to staffing issues, however, those completed in July 2023 and October 2023 reported 100% compliance. We raised our concerns with the trust following the inspection.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. 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). An audit between April and September 2023 showed CTGs had been appropriately completed in 80% of cases and staff carried 'fresh eyes' at each hourly assessment in 96% of cases, the audit identified that all CTGs had been appropriately escalated.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff 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. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to date handover sheet with key information about women and birthing people. Staff were required to dispose of handovers in confidential waste following their use. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Maternity

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

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

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

Midwifery Staffing

The service experienced issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Not all midwifery staff had had an annual appraisal of their work.

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 1 July and 31 July 2023 there were 18 red flag incidents.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. In July 2023, the board reported the trust had not always achieved its target of 100% for shift co-ordinators to remain supernumerary on 2 occasions.

The service continued to support 5 continuity of carer teams, despite the challenges faced in ensuring there were enough staff in inpatient midwifery services to ensure safe care and treatment. Between August and September Antenatal and Postnatal wards evidence provided showed there 39 instances there where 2 midwives short and 3 instances where there were 2 or more midwifery staff short. The service reviewed the continuity of carer provision following the publication of Ockenden report (2022) and the subsequent letter from NHS England. The service explored risks and benefits and the decision was made to retain the current service provision as this benefited both the women and birthing people they provided services too, as well as to ensure more staff were retained from the continuity teams.

Managers accurately calculated and reviewed the number and grade of midwives, midwifery assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in 2022. This review recommended 230.16 whole-time equivalent (WTE) midwives compared to the funded staffing of 242 WTE in July 2023, therefore no additional funding was required.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice and expected to work in areas unfamiliar to them.

The maternity directorate meeting in September 2023 reported 6.4% vacancy rate for midwives in July vacancy rates, however in October the trust confirmed 14 midwives had been recruited lowering the vacancy rate to 6%, with a further 8 were expected in November which would result in a 3% vacancy rate. Turnover rates were reported as 12.2% and sickness rates were 6.4%.

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

Maternity

Managers supported staff to develop through yearly, constructive appraisals of their work and 70% of midwives had received their appraisal. A practice development team supported midwives. The team included 2 practice development midwives, a fetal monitoring lead and a preceptorship midwife.

Managers made sure staff received any specialist training for their role. For example, band 7 labour ward co-ordinator course and had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

Medical staffing

The service did not always have 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. However, this was managed through regular reviews and adjusting staffing levels and skill mix. The service gave locum staff a full induction.

The service did not always have enough medical staff as there were gaps in rotas due to sickness and vacancies. Sickness rates for medical and dental staff within maternity services had fluctuated between June 2022 and May 2023 between 6.4% & 10.5%. The levels of sickness for this staff group in May 2023 was at 6.1%. Staff had been supported during periods of sickness through systems such as phased return. The maternity safety report for July 2023 reported 1 WTE consultant post which was out to advert for recruitment. The trust currently has over established Registrar positions with 21.6 WTE in post but are funded for 19.6 WTE. There was a 6 WTE junior grade medical staff vacancy rate.

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

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

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

Managers supported medical staff to develop through regular, constructive clinical supervision of their work and evidence provided showed 92% of medical staff had received their appraisal. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Records

Staff kept records of women and birthing people's care and treatment. Most records were clear, up-to-date, stored securely and easily available to all staff providing care. However central CTG monitoring screens displaying patient information could be viewed from patient populated areas, and staff did not always fully complete a full set of WoWs on every occasion.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 6 paper records and found records were clear, however WoWs had not always been fully completed on every occasion.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Most records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. However, we found central CTG monitoring systems were displaying patient information in a public thoroughfare, additionally this included information of women and birthing people who had moved to a different area of the maternity unit. When asked, staff told us they liked to see how their women were getting on after leaving their care, however, this meant staff may miss a concerning feature for their own women or birthing people.

Medicines

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

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

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

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

Staff managed all medicines and prescribing documents safely. Staff usually stored medicines safely however during the inspection we observed one instance of staff not locking the key safe used to store medicine cupboard keys. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines are recorded on paper based records, from the 10 sets of records we looked at were fully completed, accurate and up to date.

During the inspection we observed a member of staff drawing medication from a glass ampoule without a filter needle, this was identified as a safety concern as it increases the risk of glass particles being injected along with the medication.

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 investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 3 investigations, managers shared duty of candour and draft reports with the families for comment.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 5 incidents reported in the 3 months before inspection and found them to be reported correctly.

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

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions.

Although incidents identified ethnicity managers did not routinely review incidents in relation to health inequalities.

Managers shared learning with their staff about never events that happened elsewhere. The service shared learning from incidents through team meetings, huddles, newsletters, staff social media platforms and governance boards displayed throughout each unit. Managers debriefed and supported staff after any serious incident.

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

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed progress and outcomes of Maternity Neonatal Safety Investigations (MNSI) formally Healthcare Safety Investigation Branch (HSIB) investigations as part of the Maternity safety report July 2023 and shared learning at a Maternity Quality Governance Meeting in August 2023.

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

Is the service well-led?

Good ↑

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

Leadership

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

Maternity services were managed as part of the Women and Childrens Divisional Service. The division was managed by a Divisional Director, Director of Midwifery, Associate Divisional Director, Divisional Director of Nursing and Divisional Director of Operations. Lines of management were in place for consultant and specialist midwives, matrons, ward managers and team leaders.

Maternity

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions and non-executive directors.

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

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.

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At the time of the inspection the Maternity strategy was under review by the maternity directorate and was aligned with trust annual planning for years 2024 to 2025 to be presented in November 2023. They had developed the vision and strategy in consultation with staff at all levels in 2020 and covered a 3 year plan. The strategy identified key priorities which included: working closely with partner organisations in order to deliver holistic services that support the wider social needs, developing a second obstetric theatre and assessment area, improving compliance with national maternity safety initiatives such as the Clinical Negligence Scheme for Trusts (CNST), the Ockenden report and the Saving Babies Lives care bundle version 3.

Leaders had considered the recommendations from the Ockenden reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. The trust used a live action plan to monitor and review progress against the recommended actions.

Culture

Most staff felt respected, supported, and valued. Feedback from women and birthing people varied. With some being positive, reporting care as kind and respectful and others less positive because they felt that their care had not been delivered with kindness or respect.

Most staff felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. However, the trust wide Workforce Race Equality Standard (WRES) data collected as part of the 2022 NHS Staff Survey showed a higher proportion of staff from all other ethnic groups experienced harassment, bullying, discrimination or abuse from staff, patients, relatives, or the public in the last 12 months as well as a lower proportion of staff from all other ethnic groups believed that the

organisation provides equal opportunities for career progression or promotion. However, WRES data also showed that 48% of all staff reported believing that the organisation provides equal opportunities for career progression or promotion. Additionally, 28% of staff with a long-term condition or illness reported experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

The service encouraged divisional "thank you's" to recognise staff who have gone the extra mile, and encouraged team events such as wolf runs for charity as well as Christmas parties and monthly health and wellbeing sessions with the director and deputy director of midwifery. The service had identified additional areas where they could support their staff further including but not limited to, listening events in collaboration with University of Worcester and encouraging staff to challenge inappropriate behaviours.

Most staff were focused on the needs of women and birthing people receiving care. However, we received mixed feedback from women and birthing people during the inspection. Following the inspection, we received feedback from 709 women and birthing people in response to a poster campaign. We reviewed the feedback and found 356 of 709 responses were positive describing high quality care, stating staff were attentive and knowledgeable. The negative feedback we received highlighted concerns around slow response times related to staffing levels as well as rude staff who did not listen to women and birthing people.

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. According to the maternity safety report July 2023 the service reviewed 8 maternal deaths which had occurred between 2016 and 2023. Findings showed there was no disproportionate effect for the maternal deaths in respect to ethnic minority backgrounds.

The service supported non-English speakers through the provision of interpreting services both face to face, by telephone, and included British sign language and all other non-spoken services.

The service promoted equality and diversity in daily work. Staff were required to complete equality, equity and personalised care training every 3 years. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement.

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. Complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The directorate monitors all complaints received on a weekly basis at the Quality and Safety Review Meeting (QSRM). Patient advice and liaison service (PALS) provides advice and support to NHS patients and their relatives and carers, complaints received through this service are handled by the leadership and clinical teams, any themes noted can then be discussed. Between 1 July and 31 July 2023, 12 PALS queries were received and were being investigated in accordance with the trust complaints process.

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

Maternity

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

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

At the time of the inspection, we found a number of policies were out of date, however these were under review and at the final stages of the approval process before they were implemented across maternity services. Staff followed each policy to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies to make sure they were up to date.

We reviewed minutes of the last 3 maternity quality governance group meetings attended by the Director of midwifery, clinical director, deputy director of midwifery, matrons, obstetric consultants, and specialist midwives. A standard agenda was used to discuss topics including but not limited to risk management, key assurance documents for maternity and maternity quality reporting, compliance with Saving Babies Lives care bundle and staff training.

Management of risk, issues, and performance

Leaders and teams had systems in place to identify and escalate relevant risks and issues, manage performance, and produce, action plans to reduce their impact. Although the service had not achieved full compliance with national incentive schemes, they had detailed action plans in place and were making steady progress.

The Maternity Incentive Scheme rewards trusts meeting the ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This is through an incentive element to trust contributions to the CNST (Clinical Negligence Scheme for Trusts). In year 4 (results published May 2023), the trust had not met 7 (out of ten) safety actions. In June 2023 the trust received additional funding and were reported in the maternity safety report July 2023 to be on target to achieve 5 (out of ten) safety actions. However, the senior governance lead told us the service was on target to achieve all 9 safety actions.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. The Clinical Quality Improvement Metrics (CQIMS) identified that the trust was in line with national averages in all of the six key areas. Managers and staff used the results to improve women and birthing people's outcomes.

Leaders had identified areas for improvement within the maternity service, they had implemented action plans and were responsive to the concerns we raised with them during feedback often taking action swiftly and in depth action plans in order to mitigate further risks. Leaders had the skills and abilities to run the service. The local audit programme,

did not always collect the data leaders required in order to make fully informed decisions, making it difficult to identify and understand the priorities and issues the service faced. However, leaders and staff we spoke with were aware of current limitations and told us of plans to amend and improve the audit process in order to ensure more reliable data is captured. 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.

The trust had a programme of repeated audits to check improvement over time however we identified instances where audits may not have been fully reliable. In particular triage audits did not contain doctor review times in order to ensure compliance with trust targets, as well as surgical safety WHO audits showed 100% compliance in July 2023 and October 2023, but we observed them being completed incorrectly in one instance. The trust did not have an audit in place to monitor patient handovers in a way which ensured situation, background assessment and recommendations were covered, however they provided reassurance that this was planned to be completed in quarter 3.

The leadership team used the information to improve maternity services and were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the weekly Serious Incident Review and Learning Group. The leadership team took action to make change where risks were identified.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

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

Information Management

The service did not always collect reliable data. However, staff could find most of the data they needed, 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 had been working with the digital midwives in order to better collect and analyse data**.** Although the trust had local audit programmes in place offering some assurance, they were not always able to fully obtain sufficient data to ensure effective oversight. However, the service had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The trust used a mix of paper and electronic patient record systems. Staff had access to information required to assess performance, make choices, and make improvements could which be found in readily available formats.

The service used password-protected IT systems to safeguard and integrate the information systems.

Data or notifications were consistently sent to outside agencies, such as the Local Maternity and Neonatal System (LMNS) and Healthcare Safety Investigation Branch (HSIB).

Engagement

Maternity

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 (MNVP) to contribute to decisions about care in maternity services. The MNVP had worked with staff at WAHT to record a video about the MNVP and benefits of coproduction. There is a short version to be used generally by the MNVP and a longer version which had been approved by the trust to form part of the Personalised care session on the Mandatory Maternity Training Day. This was to help improve the understanding of the MNVP and increase the number of service users who are signposted to the service.

The Trust had also been working together with the MNVP and the LMNS Programme Team in order to better distribute information related to Induction of labour (IOL). A video has been filmed and an LMNS wide leaflet has been distributed. At the time of our inspection meetings were held bi-monthly with the MNVP, which meant the lived experience of women and birthing people had a regular voice at the table.

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

Leaders understood the needs of the local population.

We received approximately 709 responses to our give feedback on care posters which were in place during the inspection. Of these responses the majority were 356 positive, 255 mixed and the remaining 98 negative. Themes included short staffing levels with staff slow to answer call bells, full catheter bags, staff not listening to women and birthing people, not enough breastfeeding support, specialist care for women with comorbidities was inadequate, slow, or limited communication whilst waiting for debriefs. Positive feedback reported staff being knowledgeable and caring, as well as women feeling satisfied with the midwifery birthing unit.

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, Worcestershire Acute Hospital NHS Trust scored about the same for 40 questions, 'somewhat worse than expected' for 3 questions and 'worse than expected' for 8 questions. Areas of improvement identified by the survey included the quality of information provided to women and birthing people antenatally, and during labour as well as women's confidence in staff caring for women and birthing people.

Learning, continuous improvement and innovation

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

The trust began using the PERIPrem baby passport in July 2023, the package of care is used to give premature babies the best chance at birth and protect their brain. Women and birthing people were encouraged to speak with obstetric medical staff and midwives to identify which steps of the passport are most appropriate to for each baby.

The service identified the need to provide additional information to women and birthing people around induction of labour and had been making steady progress with the support of the MNVP towards this goal. At the time of the inspection an information leaflet had been developed and a video had been recorded with plans to make the information available to the local population in the near future.

Maternity

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure staff are up to date with PROMPT and pool evacuation training and complete regular skills and drills. Regulation 12(1)(2) (c)
- The service must ensure staff are up to date with safeguarding training. Regulation 12(1)(2) (c)
- The service must ensure there are enough emergency equipment across the maternity unit to ensure safe care in an emergency. Regulation 12(1)(2) (c)
- The service must continue to review and implement an improved telephone triage service. Regulation 12(1)(2) (c)

Action the trust SHOULD take to improve:

- The service should ensure that staff are following the most recent up to date clinical guidance; in particular safe practise involving medication being drawn from glass ampoules.
- The service should consider a review of their WHO surgical checklist audits to ensure they are being completed correctly.
- The service should consider a review and additional audits through the local audit programme in order to ensure effective oversight of systems and processes.

Our inspection team

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