Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal Cornwall Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Royal Cornwall Hospital.

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

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

The service provides maternity care for women across Cornwall and the Isles of Scilly, approximately 3800 babies are born at the trust each year. The maternity unit contained an antenatal ward, maternity day assessment unit and triage, delivery suite, co-located midwife-led birth centre, and postnatal ward, where transitional care was provided for babies with more complex needs. The delivery suite was located on the first floor and comprised of 6 high risk labour rooms, 4 high-dependency rooms and 2 theatres. There was a bereavement suite located on the ground floor.

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

Our rating of this location did not change at this inspection. The previous rating of requires improvement remains.

We also inspected two other maternity services locations run by Royal Cornwall Hospitals NHS Trust. Our reports are here:

Penrice Birth Centre: https://www.cqc.org.uk/location/REF81

Helston Birth Centre: https://www.cqc.org.uk/location/REFZ1

How we carried out the inspection

We inspected the service using a site visit where we observed care on the wards, spoke with staff, managers and service users, and attended meetings. We interviewed leaders and members of the executive team remotely after the site visit. We looked at online feedback from staff and service users submitted via the CQC enquiries process. The service submitted data and evidence of their performance after the inspection which was analysed and reviewed for use in the report.

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

Maternity

Good ➔➔

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

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

However:

- Staff appraisals were not up to date. Staff used a formalised handover tool but this was not embedded in practice.
- The maternity building was aging, and the environment was becoming too small for the number of babies born at the site and the necessary equipment. Several ward areas, clinical rooms and stock rooms were cluttered and may not be safe in emergency situations.
- Daily checks were completed and documented but did not always identify out of date equipment. Medicines were not always labelled with a clear expiry date once opened.

Is the service safe?

Good ➔

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it, however doctors did not keep up to date with advanced life support training.

Staff kept up-to-date with their mandatory training. Overall training compliance rates were over the trust target of 95%. Compliance was tracked between various staff groups as per Clinical Negligence Scheme for Trusts (CNST) requirements and a monthly training update was provided by the care group to the trust board via the Maternity and Neonatal Safety Report.

Maternity

Data showed 86% of midwives and 84% of maternity support workers had attended the maternity update day. This was below the trust target of 90%.

The mandatory training was comprehensive and met the needs of women and birthing people, and staff. Mandatory training included modules in safeguarding, perinatal mental health, and human factors training. Senior midwives attended leadership courses in line with recommendations in the Ockenden Report (2022). We saw evidence that training was continuously evaluated and evolved with the needs of the trust, for example the trust had implemented training for staff on informed consent following results of an audit; 12 months following the initial implementation, the trust had devised content to build on the initial training and cover more in-depth cultural competency training, with a view to continuing developing the training year on year.

Practical Obstetric Multi-Professional Training (PROMPT) was conducted face-to-face with all levels of staff taking part. PROMPT days contained training on obstetric emergencies and newborn resuscitation; staff attended neonatal life support training from the resuscitation council every 4 years. Compliance with PROMPT training was at 98% for midwives, 97% for maternity support workers and 100% for doctors of all levels.

The trust had a monthly programme of simulation training in addition to the annual PROMPT training, aiming to build on clinical skills and effective collaboration between staff.

Obstetricians and midwives completed fetal monitoring training annually, 100% of midwives, 100% consultant obstetricians and 95% of obstetric doctors had completed the training and assessment package in 2022.

Birth pool evacuation training was delivered as a one-off training session and compliance rates met the trust target. Staff also had access to pool evacuation procedure, instructions and visual aids on their intranet, including photos and videos of a successful evacuation. Since the inspection, the trust told us that birth pool evacuation is on the annual mandatory training programme.

Staff were required to complete medicines management training annually and compliance was 87.8%.

Clinical staff completed training on recognising and responding to women and birthing people with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

There was a comprehensive, up to date guideline for maternity training which contained a thorough training needs analysis taking into account recommendations from national reports and requirements from CNST.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Data as of November 2022 showed 95% of midwives and 85% of maternity support workers across the trust had completed safeguarding level 3 training.

Maternity

Safeguarding training had been developed over a number of years at the trust in response to increasing numbers of safeguarding cases in the area. The safeguarding team consisted of specialist nurses and midwives who had close links with the local authority. They worked from a dedicated multi-disciplinary hub in order to provide joined up care for women and birthing people and families receiving support.

Staff were trained to the appropriate level for their role. Safeguarding training consisted of mandatory updates and the safeguarding team provided bespoke training short courses lasting one hour that staff could access at times to suit them. Short courses covered topics such as the mental capacity act, correct referrals process, learning from local and national adverse events and many others. Each quarter there were 5 short courses available for staff to access. Short courses were developed by the local team in a responsive way to give staff access to current and topical best practice. Staff were able to request and suggest learning topics according to need in practice.

There was a safeguarding training passport to ensure staff accessed all the necessary training, and training was evaluated and updated on a regular basis. This enabled the service to maintain high standards. An overview of the safeguarding training package and training compliance levels were reported regularly to the trust board to ensure adequate oversight.

The trust had a well-established specialist team of midwives to support people throughout pregnancy who required additional support, provide continuity of care, and to provide knowledge and expertise to colleagues working both in the community and acute setting. Staff used a safeguarding timeline document to ensure all relevant professionals and services had access to contemporaneous safeguarding information about women and birthing people and their families. Staff knew how to access this and were confident with its use. We saw evidence that staff updated records regularly and there were systems and processes in place to ensure records were checked and maintained.

Community midwives had monthly supervision of safeguarding cases on their portfolios and felt well supported to provide care.

We saw evidence that the service responded to risks and adverse events and learnt from them, for example: when an area for improvement was identified, staff used debriefs, improved escalation processes, and reviewed when to refer women, birthing people and families appropriately. Learning was disseminated to staff via training days and email communication.

Staff gave examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

There was a baby abduction policy in place to support staff in the aftermath of an abduction, however it was not clear what measures were in place to reduce the risk of an abduction taking place. Baby abduction drills were practiced however not all staff we spoke to were aware of what to do in the event of an abduction.

Cleanliness, infection control and hygiene

Maternity

The service controlled infection risk. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Audits showed 97% compliance for cleanliness in the three months preceding the inspection. Audits on hand hygiene and indwelling medical devices, for example urinary catheters and intravascular lines, were compliant in the 6 months preceding the inspection. However, there were 3 out of 18 incidents where infection prevention and control compliance was between 80% and 89%, which is below the trust's target compliance rate.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after contact with women and birthing people, and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment mostly followed national guidance however, the unit was located in an aging building. The unit contained an antenatal ward, maternity day assessment unit and triage, delivery suite, co-located midwife-led birth centre, and postnatal ward, where transitional care was provided for babies with more complex needs. The delivery suite was located on the first floor and comprised of 6 high risk labour rooms, 4 high-dependency rooms and 2 theatres. There was no space for a bereavement suite on or near to the delivery suite, therefore this was located on the ground floor within the antenatal ward. This is not recommended in current national guidelines. There was a private entrance for families to gain access to the bereavement suite, and the room provided a self-contained and private area for families to stay together following the birth of their baby.

Staff carried out daily safety checks of specialist and emergency equipment. We found 2 out of 10 emergency trolleys contained out of date equipment despite emergency checks having been marked as complete. We escalated this to staff during the inspection and this was rectified immediately. We also found some out of date equipment in stores that was removed immediately when we showed staff. Managers told us that they would disseminate this for learning and improvement.

The service had suitable facilities to meet the needs of women and birthing people's families. However, the trust told us that there was a plan for construction of a new maternity unit in the next five years; this was because the estates were old and had become too small for the amount of women and birthing people and babies accessing the site for care. We found that rooms throughout the maternity unit were often small for equipment required and were cluttered. This was a potential risk in emergency situations.

Maternity

There were 2 obstetric theatres located in the main delivery suite, the second of which was small, and staff told us it was difficult to use in emergency situations. Staff told us that newer facilities were required and that the service would benefit from a third theatre being made available. Theatres had cell salvaging equipment (equipment that helps minimise blood loss during operations and reduce the need for blood transfusions) and staff told us this was used for every caesarean section.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies and equipment was tested according to recommended timeframes.

Women and birthing people could reach call bells and staff responded quickly when called. There were shared day rooms with kitchen areas for women and birthing people to use on the ante- and postnatal wards.

Staff disposed of clinical waste safely. Staff told us that staffing levels and availability of cleaners had reduced in the previous 12 months.

Assessing and responding to patient risk

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

Staff used a standardised evidence-based tool to identify women and birthing people at risk of deterioration and escalated them appropriately, at the point of telephone triage, and in person. The service had invested in a new telephony system in order to monitor and prioritise calls safely.

Staff completed risk assessments for each woman on admission / arrival, using a standardised, evidence-based tool, and reviewed this regularly, including after any incident. Managers monitored and audited the tool's use and efficacy to assure the safety of the service.

Managers monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. In November 2022 the service received 1589 triage calls and the average time it took staff to answer was 3 seconds. The longest call waiting time was 23 seconds. Data submitted by the trust showed 86% of people attending triage were reviewed within the recommended timeframe.

Shift changes and handovers included all necessary key information to keep women and babies safe.

Multidisciplinary handovers took place on the delivery suite with relevant staff present. However, the location of handovers on the delivery suit was not completely private and could be disturbed by ward activity and noise. Handovers were woman-centred and took place twice a day alongside a consultant ward round on the delivery suite as per national guidance. There was comprehensive consultant presence on-site, consultants provided a 12-hours on site seven days per week, and night-time on-call cover.

The service had 3 safety huddles per day. These were attended by maternity teams from within the main site, the community hubs, and safeguarding teams to discuss activity, outliers, staffing, and any other concerns. We saw evidence of effective communication and escalation pathways between midwifery and medical staff, and to managers where necessary. Staff told us that there was a flat hierarchy and they felt able to approach consultants and managers with any concerns. There was a high-level on-call system in place to assist managers with operational issues.

Maternity

There was a central monitoring system for cardiotocograph (CTG) monitoring on the delivery suite. Shift leaders on the delivery suite were supernumerary as per national guidance, a supernumerary co-ordinator provided a 'helicopter view' of the unit, and there was a supernumerary senior midwife allocated to telephone triage duties.

Staff knew about and dealt with any specific risk issues for example sepsis and venous-thromboembolism (VTE). Staff used the 'fresh eyes' approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people having continuous monitoring of the fetal heart in labour; the audit dated October 2022 found that fresh eyes reviews were completed appropriately, every hour, in 84% of cases. The remainder of cases had fresh eyes reviews that were either late or had information missing. The service had flagged this for further learning and review, including implementation of a CTG proforma. CTG audits were part of a rolling program of audits at the trust to monitor and improve compliance over time.

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.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people 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.

Midwifery Staffing

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

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance with them to provide support and development.

The service had enough nursing and midwifery staff to keep women and birthing people and babies safe.

Managers accurately calculated and reviewed the number and grade of midwives and maternity healthcare assistants needed for each shift in accordance with national guidance. The trust had utilised a standardised national reporting tool to calculate safe staffing numbers which showed a deficit of 16.07 whole time equivalent midwives as of March 2022. The trust told us that ongoing recruitment was in place and successful but had a deficit of 10 whole time equivalent midwives at the time of inspection. Staff had left the service due to relocation or retirement. The trust was completing a consultation of staffing needs and analysis to reflect acuity and maintain an efficient workforce. There were higher

numbers of community midwives at the trust to reflect the rural geography of the local area. Managers told us that they aimed to build a flexible workforce to cope with changing needs in the maternity unit. The final results of the consultation were not yet known, but leaders told us that the aim was to staff the women and birthing people rather than the buildings, for example, moving midwives into the areas that are busiest at the time.

The ward leader could adjust staffing levels daily according to the needs of women and birthing people. Staff told us that they were regularly moved wards to reflect acuity which was indicative of a responsive service. Staff told us that this sometimes meant there were delays in women and birthing people being discharged from the postnatal ward due to fewer staff.

The number of midwives and healthcare assistants sometimes matched the planned numbers however we saw a deficit of midwives and maternity healthcare workers on the day of inspection.

The service had low and reducing staff turnover rates.

The service had stable sickness rates, and sickness rates were monitored via the maternity dashboard. Staffing levels were monitored by managers daily, and additional staffing concerns were fed up to trust board level to ensure oversight and support from senior leaders. There were high levels of sickness in acute areas of the maternity unit however, sickness rates were low in community midwifery services. It was recognised in maternity service reports to the trust board that staff sickness was largely due to high levels of stress both at work and in staff's personal lives. The trust had been attempting to mitigate this by recognising good practice, providing incentives and fostering a positive working environment through networking training and constant review of multi-disciplinary working.

The service reported maternity 'red flag' 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. In the 3 months prior to the inspection there were no red flag incidents.

Managers limited their use of bank staff and requested staff familiar with the service.

Managers made sure all bank staff had a full induction and understood the service.

Managers sometimes supported staff to develop through yearly, constructive appraisals of their work however told us that appraisal rates had been low throughout the COVID-19 pandemic due to staffing issues. The data submitted showed 36% of midwives, 57% of maternity support workers and 32% of doctors were overdue their annual appraisal. Staff told us that managers informally checked their wellbeing but acuity had meant formal appraisals had not taken place. Low appraisal rates were recognised at the trust board and the trust was in the process of assigning lead appraiser roles to clear backlogs.

Managers made sure staff received any specialist training for their role.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe.

The actual number of medical staff matched the planned number. The service had reducing vacancy, turnover and sickness rates for medical staff. Sickness rates for medical staff were low.

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

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

The service always had a consultant on call during evenings and weekends and had a comprehensive consultant presence within obstetrics. Consultants completed 2 daily ward rounds as per national recommendations and spent the daytimes visible and available on the wards. There was a consultant present on weekdays from 8.30am until 9.30pm, and the weekend on-call consultants attended the unit in person to conduct ward rounds from 8.30am until 11.30 am, and 8.30pm until 9.30pm. There were second doctors specifically assigned to support maternity triage and day assessment unit. Staff told us doctors were approachable and were available for urgent reviews.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The service provided teaching sessions to medical staff weekly, and junior doctors told us they felt well supported and teaching at the service was high quality to meet their needs. The service managed clinical competencies of junior doctors through training and competency records. The service supported junior doctors to identify strengths and weakness in practice and improve skills through use of action plans were necessary.

The service did not have a dedicated second theatre team for emergencies and used colleagues from the site's main theatres. However, there had been no incidences where an emergency procedure was delayed or a theatre team unavailable. The impact of this was the trust's main theatre teams may potentially have a shortfall when attending obstetric emergencies. We spoke to leaders about this and they noted the risk was mitigated adequately at the time of inspection.

They told us that optimal staffing including obstetric theatre teams was included in business cases being considered as part of the operational planning requirements and prioritisation process for CNST and Ockenden requirements.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive and all staff could access them easily. Six out of 6 sets of patient records had appropriate CTG 'fresh eyes' monitoring and documentation as per NICE guidance, documented swab count, consent for surgical procedure, fetal movement monitoring, fetal growth monitoring and maternal early obstetric warning signs (MEOWS) charts. However, we found evidence that notes were not always documented in full, for example: 6 out of 6 sets of patient records did not have any documentation regarding Vitamin D supplementation in pregnancy, 6 out of 6 records contained entries or documents that were not completed in full with date, time, signature and designation, 1 out of 6 had not had a venous thrombo-embolism (VTE) assessment, and 1 in 6 did not have a triage risk assessment. The trust provided evidence that regular audits were performed to monitor standards of record-keeping, and any areas for improvement noted and actioned, either with individual staff members or by using shared learning.

Average record keeping compliance for the 3 months preceding the inspection was 92%. The December 2022 audit of 71 randomly selected sets of notes from across the service showed compliance was 90%.

Staff used a situation, background, assessment, recommendation (SBAR) format to share information. The last SBAR audit completed in November 2022 of 16 sets of notes selected randomly from across the service showed the tool was used in 55% of cases and was not fully embedded in the maternity service. The trust had identified this area for improvement and monitored use of SBAR. Staff were encouraged to continue use of SBAR as shared learning via emails and trust 'top tips' communications with staff. A handover document had been introduced to improve the quality and consistency of information shared at handovers and to ensure accurate documentation of the discussion. Ongoing audits for SBAR handover were in place and the service monitored compliance and communicated with staff on the importance of improved documentation through newsletters, posters and interactive learning.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Records were a combination of paper and electronic. The trust told us there was a digital strategy in place in order to implement an electronic records system.

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

Medicines

The service used systems and processes to safely prescribe, administer and record medicines however the service did not always store medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records accurately and kept them up to date. The trust used electronic prescribing. We reviewed 5 sets of medicines records and found that medicines were prescribed and documented safely however, it was not clear whether maternal weight was recorded on this system for clinicians to review when prescribing.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people and carers about their medicines.

Staff stored and managed all prescribing documents safely.

During the inspection we found that medicines were not always stored safely. Some medicines were opened and not dated correctly; therefore, staff were unsure when medicine was due to expire. We escalated this immediately to the trust and staff removed medicines that were not dated. Managers told us they would ensure practice was improved. We also found old stocks of a controlled drug prescribed to an inpatient who had been discharged. Staff told us they had requested pharmacy collection and destruction of this medicine, but it had not been actioned by the pharmacy team. We escalated this to managers, they told us that pharmacy staffing levels were suboptimal within the trust, however it would take urgent action to remove the controlled drug safely. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation outside of recommended parameters.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or they moved between services.

Maternity

Staff learned from safety alerts and incidents to improve practice.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Managers investigated incidents thoroughly. Women and birthing people and their families were involved in these investigations.

The trust had a process for managing and reviewing incidents. There were no incidents over 60 days old however, we found 18 of 123 incidents were overdue in the review process according to local timeframes, and there were further incident records awaiting final approval to be closed.

The service had not had any never events on any wards.

Managers shared learning with their staff about never events that happened elsewhere and looked to external incidents to encourage learning.

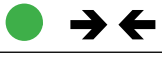
Staff reported serious incidents clearly and in line with trust policy. The trust held weekly review meetings to discuss current cases and recommendations from the Healthcare Safety Investigation Branch (HSIB) and any serious incidents. The meetings were attended by midwifery managers, board level leaders including the Chief Nursing Officer and Maternity Safety Champion, and speciality midwives. Learning and risk was identified and actioned quickly to improve care for women and birthing people without delay whilst awaiting initial feedback and final reports.

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

There was evidence that changes had been made as a result of feedback, for example introduction of a hyponatraemia (low sodium levels in the blood) guideline to avoid and treat women and birthing people at risk, and changes in the management of breech presentation including research participation and extra training for staff. Another case identified CTG monitoring and interpretation as a contributing factor in a poor outcome. The trust provided a comprehensive action plan that had been put in place and actioned in a timely way to improve safety.

Managers debriefed and supported staff after any serious incident. The trust had introduced training for staff psychological wellbeing following involvement in any traumatic event.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Maternity

Leadership

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

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

Leaders were visible and approachable within the service for women, birthing people and stall. Leaders at all levels were well respected, approachable and supportive as part of a flat-hierarchy leadership model. 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 told us how accessible and encouraging they were.

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

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

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The service had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services at The Shrewsbury and Telford Hospital NHS Trust and had started to revise the vision and strategy to include these recommendations. We saw evidence that a new strategy for maternity services was being developed for launch in 2023. The trust was compliant in all of the safety recommendations from Ockenden 1 and was working towards full compliance for Ockenden 2.

Leaders and staff understood the vision and knew how to apply the strategies and monitor progress.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

There was a specific strategy for workforce recruitment and retention and progress was measured using key performance indicators embedded in the maternity dashboard and was reported to the local maternity and neonatal system.

Culture

Maternity

Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff 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.

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

Staff told us that they enjoyed working at the trust and that they felt included as part of a wider team. Staff were offered incentives and rewards in recognition for good work, and various teams and staff members had received awards and commendations nationally for good practice. Staff told us that there was support and encouragement from the director of midwifery and other senior leaders.

Results from the NHS Staff Survey 2021 showed maternity staff were positive about their work, felt safe to raise concerns and confident leaders would listen to them. Staff said managers and the organisation cared about their wellbeing.

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. This was shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach 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.

There were 6 complaints received by the service in September and November 2022, 5 of these were informal however, all complaints were investigated, responded to and closed at the time of inspection.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. There were effective patient complaints and birth reflections services which fed into service-user feedback collated by the trust and used to drive improvement.

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.

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 care group management team. Information was shared with sub-committees and all staff.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

Guidelines were regularly reviewed and updated to reflect current changes in best evidence-based practice, for example updating references to the professional midwifery advocate (PMA) role following national reporting in 2022.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was open communication between maternity leaders and the trust trust board, supported by risk and oversight meetings that took place regularly.

The trust used a comprehensive maternity dashboard in order to monitor performance and risk, review issues, and ensure the trust board had adequate oversight of issues arising within maternity services. Senior leaders had good oversight of the dashboard and any emergent risks or concerns. We saw evidence that the trust identified issues within the dashboard, investigated these issues to understand why they had happened, and took steps to mitigate. For example, the trust identified an increase in the number of babies born before the mother arrived at hospital and commenced an audit and review programme. We saw evidence that the trust had examined increased rates of postnatal readmissions of both mothers and babies during 2021; the trust audited this, presented results regularly to the governance meeting, examined guidelines, training and the postnatal pathway to identify areas for improvement, and has seen a reduction in readmissions throughout 2022. The impact of this is that women, birthing people and babies received safer care and remained at home with less intervention.

The top risks identified by the trust were uniform across the staff we spoke to; staff and managers had good oversight of existing and emergent risks. The service risk register was comprehensive and up to date.

The service participated in relevant national clinical audits. Managers and staff used the results to improve women and birthing people's outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust employed a dedicated audit midwife and performed rolling audits on many areas of performance for example: documentation, smoking in pregnancy, postpartum haemorrhage, intrapartum transfers, all areas of the triage process such as calls received, time women and birthing people spent waiting, and whether women and birthing people were reviewed appropriately and in a timely manner. The impact of continued audits was the service had awareness of ongoing and developing issues, acted on them to ensure the service was safe, and identified areas for improvement. An example of this was the trust had identified the triage process as an area for improvement; it subsequently commissioned a new telephone system to monitor calls, and developed new processes and systems within triage, including a standardised tool to prioritise women and birthing people safely.

Managers shared and made sure staff understood information from the audits.

There were plans to cope with unexpected events. They had a detailed local business continuity plan, and processes to manage implementation and de-escalation of it. We saw evidence of clear documentation, assessment and communication around use of the business continuity plan.

Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards.

The service was accredited by Baby Friendly Initiative (BFI) and was working towards attaining gold status.

Information Management

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

The service used a combination of electronic systems and paper records to document care.

The service collected reliable data and analysed it. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for managerial review, internal benchmarking and comparison.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure. However, staff were required to access several different systems and paper records to find the information that they needed, which sometimes made work time-consuming. The trust had an 18-month programme in place for digital transformation in line with national recommendations. Leaders told us a system had been selected and a digital midwife had recently come into post to drive the transformation.

Data or notifications were consistently submitted to external organisations as required.

Engagement

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

Maternity

Leaders worked with the local Maternity Voices Partnership (MVP) in decisions about patient care. The trust had an active MVP that was implemented in 2018; the MVP chair told us they were well embedded into the service and the trust was open in its engagement with the MVP and women and birthing people using the service in order to drive improvement. The trust reported the best-funded MVP in England. We saw evidence that the MVP was active within the trust and their advice was welcomed at trust board level. The MVP had a direct line of contact with the maternity safety champions that sit at trust board level and told us they were approachable, and the culture was positive and open.

The MVP chair told us senior leaders at the trust welcomed challenge and actively included MVP views within regular assurance and governance meetings. For example, the MVP identified areas for midwives to be trained in personalised care and informed consent to improve women and birthing people's safety and experiences during pregnancy and birth. The MVP worked alongside women, birthing people, midwives, obstetricians and anaesthetists to co-develop and co-deliver a training package which supported all staff groups to increase their confidence and understanding around informed decision making, unconscious bias and documentation. This training package was included in PROMPT training and is developed annually to build on depth of knowledge. We saw evidence that medical and midwifery staff routinely used the BRAIN acronym (benefit, risks, alternative, intuition, next steps) to document discussions with women and birthing people; demonstrating clear that a comprehensive discussion had taken place. We saw clear documentation and discussion aids for women and birthing people and midwives that had been produced with the MVP. These incorporated the BRAIN acronym. As a result, women and birthing people were encouraged to actively consider treatment options, and doctors to consider the personal impact of care on women and birthing people as individuals.

The MVP was instrumental in drafting patient safety information on transfer times from rural areas into the hospital for women and birthing people to make informed choices regarding their preferred place of birth.

Trust guidelines had been produced with support and advice from the MVP which resulted in more accessible language for women, birthing people and families to understand; feedback from midwives was this made the guidelines more user-friendly and easier to discuss with women and birthing people when co-planning care.

The MVP chair told us there were a variety of ways the trust reached out to the community for feedback and to obtain a diverse patient voice, including those from vulnerable groups.

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

Leaders understood the needs of the local population which included women and birthing people living in rural locations, a high number of safeguarding cases and families on low incomes.

Leaders told us they had worked with neighbouring trusts to share learning and areas of best practice and this was instrumental in reducing the number of term babies that required admission to the neonatal unit.

The trust ran quality improvement initiatives using staff engagement and asked staff for ideas on where improvements were required and what solutions staff had to concerns, risks and issues. This resulted in good working relationships and communication between leaders and staff. An example of improvement made by this programme was implementation of a full 24-hour bereavement service for families, ongoing renovation to staff areas, and implementation of quality improvement ambassadors.

Staff at the trust worked closely with the local authority and external stakeholders to improve outcomes for women, birthing people and their families, for example: organisations working specifically with young fathers, young mothers,

and health visiting teams. We saw evidence of the trust working to reinstate schemes such as the family nurse partnership as a renewed need for the role had been recognised. Safeguarding teams at the trust had trained teams of community support workers to deliver extra packages of care to vulnerable families during pregnancy and ongoing support following postnatal discharge from maternity services.

Midwives worked alongside local contraceptive services to provide postnatal contraception services to 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.

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 performing well in outcomes for premature babies (born before 37 completed weeks gestation) and placed in the top 5% of trusts nationally. The service provided an innovative package of care tailored to premature babies, including equipment to be able to resuscitate babies born by caesarean section next to their mothers, facilitating optimal cord clamping.

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.

Maternity safety champions told us listening to patient voices was integral to continued learning at the trust, and extruding themes for learning was done by triangulating patient experience with reports, audits and outcome data.

Leaders encouraged innovation and participation in research. The trust employed a research midwife, and local research projects were regularly led by senior midwives. The trust was participating in a national breech birth study at the time of inspection. The service collaborated with regional universities and charities to support research studies.

Outstanding practice

We found the following outstanding practice:

- The service had a highly evolved, embedded and valued Maternity Voices Partnership that was able to actively ensure women and birthing people and families' voices were heard by the trust and used to make worthwhile improvements. For example: positive language cards, patient information leaflets including risks and information on ambulance transfer times, discussion tools, informed consent training for staff and more.
- The safeguarding team was well developed to ensure families had access to the best support available. The team had developed in-house multi-agency training in order to inspire and engage staff when caring for vulnerable families. Training was dynamic and flexible to meet the needs of staff and families and aimed to mitigate the risks associated with the sharp increase in safeguarding cases received by the trust during the past 12 months.

Maternity

- The trust is part of a regional rollout of innovative practice for premature births and this has led to the trust performing in the top 5% of services nationally in outcomes for premature babies.

Areas for improvement

Action the trust SHOULD take to improve:

Royal Cornwall Hospital

- The service should ensure daily checks are completed and accurate, including ensuring that medicine and equipment is checked for expiry dates.
- The service should ensure all records are documented in full, including staff to identify their designation, sign and date all entries.
- The service should evaluate current training provision for emergency evacuation of the birth pool and ensure birth pool evacuation simulations are carried out to ensure all staff are confident and proficient to carry out this procedure in an emergency.
- The service should ensure staff are aware of the baby abduction policy, the policy is strengthened to include preventative measures, and that staff of all levels are involved in live simulations.
- The service should consider the facilities available and any way to improve and modernise the space available to ensure the safest layout to provide care, including decluttering.
- The service should ensure clear documentation and guidance is available to staff regarding midwife exemption and patient group directive medicine.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three CQC team inspectors, a clinical obstetric specialist advisor, and two clinical midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Regulatory Leadership (Secondary and Specialist Healthcare).