University Hospitals of North Midlands NHS Trust

Royal Stoke University Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal Stoke University 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 Stoke University Hospital.

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

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

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

Our rating of this hospital stayed the same. The Royal Stoke University Hospital is rated as requires improvement overall.

The inspection was carried out using a post-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visit, we conducted interviews with senior leaders and reviewed feedback from women and birthing people and their families about the trust.

Royal Stoke University Hospital is the main site for maternity services for the trust, with County Hospital providing a full range of antenatal and postnatal services. There were around 6400 over 12 months. It comprises of a delivery suite with maternity theatres, induction of labour beds and enhanced recovery area. There are post and antenatal wards, a midwifery birth centre, a day care assessment area and maternity assessment unit (triage). The service also provides specialist substance misuse clinics, perinatal mental health and lifestyle clinics, fetal medicine and maternal medicine services. These services are available to women and birthing people from across Stoke-on-Trent and Staffordshire.

University Hospitals North Midlands NHS Trust comprises of Royal Stoke University Hospital and a Freestanding Midwifery Birth Unit (FMBU) at County Hospital, Stafford.

At the time of our inspection intrapartum care was suspended at County Hospital, however, all other antenatal and postnatal services at County Hospital were still available.

Demographic data shows a higher proportion of mothers were in the most deprived deciles at booking compared to the national average (18% in the most deprived decile compared to 14% nationally and 17% in 2nd most deprived decile compared to 12% nationally). A report completed in 2022 showed an increase in patient complexity for women using delivery suite services with many of those using the services categorised as moderate and high risk.

Our findings

Following this inspection, under Section 29A of the Health and Social Care Act 2008, the trust was served a warning notice requiring them to make significant improvements to the safety of the service. The trust wrote to CQC to submit an action plan and confirm the immediate actions taken to improve the safety of the service. The trust has kept CQC informed of progress on improvements. We found that the service had deteriorated since the last inspection on February 2020.

How we carried out the inspection

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

Requires Improvement  

Our rating of this service went down. We rated it as requires improvement because:

- People were not always able to access the service when they needed it without having to wait longer than the trust targets and as recommended in national guidance. There was a lack of embedded processes to triage and prioritise care and treatment for women and birthing people who attended the service.
- Staff did not always have training in key skills, to ensure safe treatment of women and birthing people. However, staff we spoke with could describe how to escalate safeguarding concerns. Staff took every opportunity to protect women and birthing people from abuse.
- The design and equipment were not always suitable to meet the needs of women and birthing people. Equipment was not always available for use leading to delays in treatment for women and birthing people.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- The service used systems to monitor performance and risks. However, staff did not always follow trust guidance to identify and escalate associated risks to women and birthing people. Leaders did not have effective oversight and there was a risk improvements were not always identified or made when needed. In addition the service did not provide a local business continuity plan. We were unable to determine what the arrangements were should an unexpected major event occur.
- Leaders had the skills and abilities to run the service. Leaders had identified and implemented systems to address and improve services in order to better manage priorities and issues the service faced. There were however, areas where the leadership could develop further. In particular, inconsistent incident reporting processes reduced effective oversight and reduced the ability to identify themes and trends. Staff mandatory training did not meet trust targets, and staff did not always follow processes as outlined in guidance.

However:

- The service-controlled infection risk well and managed clinical waste well. Staff kept detailed care records and they managed medicines well.
- The leadership team were visible and approachable in the service for women and birthing people and staff. Staff understood the service's vision and values, and how to apply them in their work. Most 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.

Is the service safe?

Inadequate  

Our rating of safe went down. We rated safe as inadequate.

Mandatory training

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The trust provided mandatory training in a range of key skills to all staff. Systems were in place to monitor mandatory staff training compliance. Reports indicated improved staff training compliance rates showing that actions taken had been effective. At the time of the inspection however, not all staff were up-to-date with their mandatory training.

Records shared with us at the time of inspection identified that midwifery staff and antenatal medical staff had not all completed their mandatory training courses against a trust target of 95%.No information was shared for staff training compliance for level 3 safeguarding adults and records showed that safeguarding children training level 3 for the Nursing and midwifery registered staff group was at 72%". Records showed 73% of staff had completed neonatal life support training. However, improvements had been made with training reports between January 2022 and December 2022 showing improved staff compliance in cardiotocograph (CTG) with 93% of staff having completed cardiotocograph training as well as improved compliance in K2 training and Skills and drills.

Training programmes ensured staff received multi-professional simulated obstetric emergency training and included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies However, the service did not provide information on how many staff had completed this training.

Safeguarding

Staff had not always completed safeguarding training on how to recognise and report abuse in line with trust targets and in line with national guidance. However, staff we spoke with understood how to protect women and birthing people from abuse.

Training records showed staff had not always completed both safeguarding adults and safeguarding children training at the level required for their role as set out in the trust's policy and in the national intercollegiate guidelines. No information was shared for staff training compliance for level 3 safeguarding adults and safeguarding children training (level 3) was 58% overall compared with a target of 95%.

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 understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act (2010).

Staff knew how to identify adults and children at risk of, or suffering, significant harm. We found documented correspondence with social workers for women and their children who had known risk factors indicating possible safeguarding concerns.

Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system.

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

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning audits were completed, and records were up to date demonstrating that all areas were cleaned regularly.

The service generally performed well for cleanliness; a cleaning audit completed on 26 January 2023 in Maternity Theatre showed 95.5% overall compliance across 377 measures.

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 year compliance was consistently above 96%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use with ‘I am clean’ labels to state when it had last been cleaned.

Staff regularly checked birthing pool cleanliness following a standard operating procedure and tested the water for legionella.

Environment and equipment

The design of the environment was not always suitable to meet the needs of women and birthing people. Equipment was not always available for use leading to delays in treatment for women and birthing people. However, staff managed clinical waste well.

The service did not always have suitable facilities to meet the needs of women and birthing people's or their families. We found that women and birthing people waiting to be triaged were being asked to wait alone without the support of their birth partners. Women and birthing people waiting areas were not visible to staff. Checks were not carried out by staff while women and birthing people were waiting, which may have resulted in delays for treatment. We raised this with leaders following the inspection and the trust took immediate action to relocate the waiting area to a more visible area allowing staff to effectively monitor people who were waiting.

Staff we spoke with described having to travel to other clinical areas to obtain cardiotocograph (CTG) machines as there were not enough of them. At the time of the inspection, the service was in the process of updating their CTG machines. There were pool evacuation nets in all rooms where they might be needed and on the day assessment unit, there was a portable ultrasound scanner and enough observation monitoring equipment to monitor women and birthing people.

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Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. However, signage and information leaflets were not visible in patient waiting areas in languages representative of the local population.

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

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always identify and act on women and birthing people at risk of deterioration. Staff used risk assessments and took action to remove or minimise risks but were not always able to provide treatment within agreed timescales.

Staff did not always identify and escalate risks to women and birthing people within agreed timescales. The service used nationally recognised tools to identify women and birthing people at risk of deterioration, this included national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 7 MEOWS records and found staff completed them and knew how to escalate concerns to senior staff. However, on the day of inspection we could not be assured that all staff used these tools correctly. During the inspection we observed staff changing blood pressure cuffs sizes inappropriately thereby reducing the patients risk score. This increased the risk that women and birthing people were not identified as deteriorating and appropriate escalation taken when required. In addition, staff completed a quarterly MEOWS audit of 59 records to check they were fully completed and escalated appropriately. The audit showed consultants did not always review women and birthing people who were at risk of deterioration. Audit results showed the consultant reviewed women and birthing people with a MEOWS score >6 in 28.8% of cases between January and November 2022. It was not clear what the reasons were for this low rate of review, furthermore, it was not clear if any action had been taken to improve.However, following the inspection, we received additional assurance from the trust. The trust had changed their guidance and audit standard and had achieved 100% compliance with consultant attendance in incidents where the MEOWS score was >6.

Women and birthing people were not always seen within target time frames. Staff completed risk assessments for women and birthing people on arrival using a recognised tool. The maternity triage waiting times for review audit for October 2022 to December 2022 showed midwives reviewed 75% of women and birthing people within 30 minutes of arrival, however this meant that 25% of women were seen outside of target times. The triage tool used stipulates triage should be completed within 15 minutes. Following the inspection, the service reviewed their processes and made action plans to improve adherence.

Women and birthing people had access to a dedicated maternity triage telephone line which was staffed by a midwife at all times.

Leaders audited how effectively staff monitored women and birthing people who presented with reduced fetal movements. An audit 1 Oct 2022 to 31 December 2022 showed staff had used cardiotocograph (CTG) (a machine that issued to monitor the fetal heartbeat and the uterine contractions during pregnancy) monitoring 98% of the time for women presenting with reduced fetal movements and a known history of reduced fetal movements. An audit in August

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2022 showed 88% of women and birthing people had been monitored throughout their labour using continuous use of (CTG) every hour following 'fresh eyes' guidance (checks completed hourly by staff). This was outside of service targets. Following the inspection, the provider told us that a recent audit completed in March 2023 demonstrated 98% compliance.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks and used them to inform their clinical decisions.

Women had access to mental health support through the Perinatal Mental Health (PMH) service where clinics were offered at Royal Stoke University Hospital or at County Hospital. Staff could refer and seek assistance to support women and birthing people with risk indicators and/or mental health concerns.

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 person'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. We attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 1 safety huddle a shift to ensure all staff were up to date with key information. There were additional localised team meetings staff shared key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

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

At the time of the inspection, the service was not providing transitional care for babies who required additional care, the unit had been closed due to staff shortages, this meant that babies were then seen instead on the postnatal wards. The service had taken steps to increase staffing numbers.

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

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. However, the service used recognised tools to assess staffing levels to meet the need of women and birthing people and their babies.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

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 (2015). A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing.

In December 2022, there were 143 red flags incidents of safe staffing reported via their electronic incident reporting tool, this being a low number in comparison to 358 (average number reported from July to December 2022.

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The service offered a supernumerary shift co-ordinator who had oversight of the staffing, acuity, and capacity to offer 1:1 care during active labour. The service also offered flo-co-ordinator with the role of flow improvement throughout the service. The delivery suite co-ordinator could focus on the delivery suite and was not responsible for any other flow. Additionally, staff were able to contact leadership on call if required, which was available 24 hours a day.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance on 22 February 2022. This review recommended 271.88 whole-time equivalent (WTE) registered midwives and midwifery support workers compared to the funded staffing of 228.98 WTE, a shortfall of 42.9 WTE staff.

In an attempt to reduce this shortfall, the service had developed a workforce plan with input from NHS England direct support and was working with the local university in order to recruit newly qualified midwives. The service funded midwifery apprentice positions as well as recruiting international midwives. In addition, the service had agreed a business case for further funding in November 2022, to recruit additional midwifery staff and ongoing midwife recruitment campaign. The service had planned a midwife recruitment event to be held on 22 March 2023. In response to the high vacancy rates, managers were able to request bank staff familiar with the service and made sure all bank and agency staff to ensure vacancies were covered. Agency staff were given a full induction and understood the service. At the time of the inspection the service had improved staffing numbers by 22 WTE reported, the service reported being on target to reduce this to 10 WTE by the end of 2023.

The service managers had the resources to adjust staffing levels daily according to the needs of women and birthing people when staffing was particularly tight. Managers could access additional staffing via bank staff and could move staff according to the number of women and birthing people in clinical areas on a priority basis allowing the service to mitigate risks more effectively.

According to electronic staff records sickness rates had improved with a 4.9% reduction in reported staff sickness for nursing and midwifery staff from November 2021 to November 2022.

Staff did not always receive annual appraisals. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The leadership team recognising the need for improvement in this area. As a result, appraisal rates formed part of their improvement programme (Improving Together), which was discussed and monitored at trust executive level each month. At the time of the inspection approximately 60% of all staff groups had completed their yearly appraisal.

There was a well-structured team made up of a range of midwifery service and allied professionals, designed to meet the needs of people who accessed and used the services.

The service made sure staff were competent for their roles. There was a preceptorship programme for newly qualified midwives, and this included competence assessment in different skills. Managers told us staff received specialist training for their role supporting documents were provided detailing what training was offered to specialist staff however staff training compliance was not provided.

Medical staffing

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The service had enough medical staff in line with national standards in relation to the number of births 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.

We found there were sufficient medical staff working at the service in line with national standards in relation to the number of births. Internal audits completed between October 2022 and February 2023 showed staff had not always attended situations where they "must" attend according to the standards set out by the trust (Delivery Suite Staffing Guideline (Dec 2022)). Following the inspection an audit completed in March 2023 showed all staff had attended where they "must" according to service guidelines. The service had low vacancy, turnover and sickness rates for medical staff.

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

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. 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 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. However, safeguarding checks were not always completed with women and birthing people during appointments.

Women and birthing people's notes were comprehensive however risk assessments and checks related to safeguarding had not always been completed. Staff could easily access the notes and the trust used a combination of paper and electronic records.

We reviewed a sample of 8 set patient records, records were clearly documented and safeguarding checks had been completed during appointments. Records were stored securely. The service used an end-to-end maternity information system. This allowed two way noting and service users to view their own records. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service had improved its medicines management and 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 7 prescription charts and found staff had correctly completed them.

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

Staff completed medicines records accurately and kept them up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation outside the ideal range.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Of the 7 sets of medicine records, we looked at we found all 7 had been fully completed, were accurate and up-to-date.

Staff learned from safety alerts and incidents to improve practice.

Incidents

Staff recognised and reported incidents and near misses, but the level of harm was not always recorded correctly when staff reported an incident.

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, as well as issuing duty of candour letters in their 1st language. Managers ensured that actions from safety alerts were implemented and monitored.

Staff we spoke with could describe what incidents were reportable and how to use the electronic reporting system. Staff regularly reported incidents and knew how to report them. However, between January 2022 and January 2023 we found discrepancies in the level of harm reported which did not correlate with the length of time patients had waited to receive treatment. We reviewed a sample of incidents reported by the trust through the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS) data and found examples of incidents where significant harm had occurred with the potential for further complications that had been graded as "No harm" and "Low harm." Following the inspection, the trust agreed to complete a review of their incidents to ensure their staff were following their processes in line with their policy.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Managers investigated incidents thoroughly. They involved women, birthing people, and their families in these investigations and recorded ethnicity as part of the review process. We reviewed 13 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all 13 investigations, managers shared duty of candour and draft reports with the families for comment.

Managers shared learning with their staff about never events that happened. The service had Lead Midwives for Development and Education who shared learning from incidents with staff.

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Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning with those involved during follow up meetings. A quarterly report completed 7th December 2022 described what action was taken in response to learning identified through serious incident analysis. This included ensuring that further pilots for improving clinical escalation, to reminded staff of the importance of declaring the urgency of an emergency as well as implementation of tools to assist staff to escalate concerns through effective and assertive communication.

Managers debriefed and supported staff after any serious incident. Staff told us they were supported through feedback discussions, exploring incidents as well as potential improvements to the care of women and birthing people.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident.

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. Following the inspection, the service told us when sending letters to patients this was done so in the patients first language. 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.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. Systems were in place to understand and manage priorities and issues the service faced, however these systems did not always work as intended. The leadership team were visible and approachable in the service for women and birthing people and staff.

Leaders had the skills and abilities to run the service, however despite being aware of the challenges to quality and sustainability within the service and having plans in place to manage them, these plans had not achieved the targeted outcome at the time of inspection. Actions taken to address identified issues were not effective, for example staff training compliance and appraisal rates remained outside of trust target levels, in addition these were improvement requirements stipulated as part of the previous inspection carried out in 2020 and had not been met.

Leaders were visible and approachable in the service for women and birthing people and staff.

Most staff we spoke with told us that leaders were well respected, approachable, and supportive.

Staff told us they were well supported by their line managers, ward managers and matrons.

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

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Staff were supported 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. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. An action plan had been created in response to the Ockenden findings and progress was measured against them.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service worked alongside the Local Maternity and Neonatal System (LMNS), Maternity Voices Partnership and Healthcare Safety Investigation Branch in addition to other services to better respond to the needs of the local population.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Most staff felt respected, supported, and valued. They were focused on the needs of women and birthing people and their babies receiving care. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Most staff we spoke with told us they felt respected, supported, and valued. However, some staff did not feel that all staff were treated equally and that disagreements between staff were impacting on patient care. Most staff we spoke with told us they felt safe to escalate their concerns within a supportive culture, however some staff working for the trust expressed a lack of faith in the leadership team and told us they were not always treated with dignity and respect. The service had taken steps to address issues related to staff culture. They had created a maternity leadership roadmap and toolkit, offered further staff training, and created fellowship programmes aiming to develop opportunities for staff and upskill the workforce.

Most staff we spoke with were focused on the needs of women and birthing people receiving care. However, staff we spoke with reported staff did not always demonstrate dignity and respect as part of the staff culture which had disrupted the effectiveness of systems used to provide high quality care. At the time of the inspection the leadership team had implemented several initiatives to address cultural concerns through a cultural improvement program and leadership development.

Leaders were aware of how health inequalities could affect the treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. Some systems had been

implemented such as smoking cessation to reduce unwanted outcomes for women and birthing people as a response to the needs of the local population. However, despite monitoring outcomes and investigating data to identify when ethnicity or disadvantage affected treatment and outcomes, responsive processes were not in place to improve outcomes for women and birthing people from ethnic minority groups.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear, staff were aware of who the freedom to speak up guardian was and were encouraged to speak with them or other specialist members of staff if they required support. Women and birthing people, relatives, and carers knew how to complain or raise concerns. We reviewed 28 complaints which had been made between August 2022 and March 2023 and concerns were in accordance with their policy the service used a formal approach applicable to each complaint. 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.

Managers investigated complaints and identified themes and shared feedback with staff through regular meetings across different levels where learning was used to improve the service.

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

Governance

Governance processes were not always effective, specifically related to leaders' ability to identify trends and themes around serious incidents as staff graded harm differently. Any learning that was identified was shared with staff at all levels, and they were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Although there were governance processes throughout the service and partner organisations, systems for oversight could be strengthened. In particular, staff did not always report incidents to reflect the potential harm level correctly in accordance with the trust's guidance. If incidents are not graded correctly effective validation cannot be fully assured, as the trust rely on input data to ensure oversight allowing trends or themes to be identified to improve treatment and care.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. The trust had an up-to-date maternity dashboard which was used to monitor performance and key metrics. Key staff took part in a quarterly perinatal mortality review tool (PMRT) meeting, which were held regularly as part of the Clinical Negligence Scheme for Trusts (CNST) these meetings were used to monitor the performance of the trust and identity any learning opportunities where improvements could be made and additionally monitored outcomes by ethnicity and deprivation.

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored key safety standards of policies such as "Saving Babies Lives Care Bundle" through regular policy reviews every 3 years to make sure they were up to date.

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Management of risk, issues, and performance

The service used systems to monitor performance and risks. However, staff did not always follow trust guidance to identify and escalate associated risks to women and birthing people. This meant leaders did not have effective oversight and there was a risk. Improvements were not always identified or made when needed. In addition, the service did not provide a local business continuity plan so we could not be assured staff knew what to do if an unexpected event happened.

The service participated in relevant national clinical audits. According to the National Maternity & Perinatal Audit published 2022 as part of the Rapid Quarterly Reporting based on births from August 2021 to July 2022 showed service outcomes for women and birthing people were better than the national average for babies born

small for gestational age.

Babies and term babies scoring less than 7 on a test performed at 1 and 5 minutes after birth to determine the physical condition of the newborn (higher numbers indicate better health). Additionally, according to MBRACE (2021) still births were lower for the group average.

Although the service carried out audits these did not always lead to positive changes For example, not all staff had completed their mandatory training at the time of the inspection and although actions had been taken to improve triage processes in line with trust target times frames, 25% of women were triaged outside of these times.

Leaders identified and escalated relevant risks and issues through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team identified and took actions to reduce the impact of identified risks through the use of a risk register. However, we continued to observe delays for women attending triage despite serious incidents concluding triage process had not functioned as intended.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily. However, during our inspection, we found not all items were in date. At the time of the inspection the trust relied on staff to complete the checks with limited oversight, in particular there were no audits being completed to ensure staff compliance.

The service did not provide a local business continuity plan at the time of inspection so we could not be assured comprehensive plans were in place to cope with unexpected events. However, whilst we were on site there was a security alert issued to the service, staff were observed responding swiftly to the potential risks.

Information Management

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

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

Maternity

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 with password protected IT systems**.**

Data or notifications were consistently submitted to external organisations as required including Healthcare Safety Investigation Branch (HSIB) and Local Maternity and Neonatal System (LMNS).

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. Communication between MVP and the service allowed for women raising concerns through social media to be flagged and addressed at the time of concern, including support for women struggling with anxiety whilst attending the service. The trust told us they were reviewing levels of literature and information leaflets representing the local diverse population in order to provide information to those population groups.

The service took part in maternity patient survey between 1 February to 28 February 2022 and received 220 responses. The survey found that people involved in the mother's care were not able to stay with mothers as much as the mother wanted during their stay in the hospital and were not as involved during labour and birth as they would have liked. Mothers were not always offered a choice where they would like to have during antenatal care, and felt they were not given enough information from either a midwife or doctor to help decide where to have their baby. Additionally, when contacting the midwifery team, women and birthing people reported not always receiving the help they needed during pregnancy.

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

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.

A team of specialist midwives were in place improve services through continuous learning and improvement. 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 had plans in place to improve training and innovation. They had a quality improvement training programme and a quality improvement lead who co-ordinated development of quality improvement initiatives.

Areas for improvement

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

Maternity

Action the trust MUST take to improve:

Maternity

- The service must ensure that systems are in place to ensure effective triage and escalation processes are in place to reduce risk of patient harm (Regulation 12 (2) (b)).
- The service must ensure staff are up to date with maternity mandatory training modules, including safeguarding adults and child protection training. Regulation (12 (1) (2)(c)).
- The service must ensure that staff complete regular skills and drills training (Regulation 12 (1) (2)(c)).
- The service must ensure the environment used to care for and treat service users is adequate for the needs the women and birthing people using them and that any identified risks are mitigated (Regulation 12 (2) (b)).
- The service must ensure systems or processes in place operating effectively in that they enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular risks identified with current maternity triage processes and effective oversight such as emergency equipment checks (Regulation 17 (2) (b)).
- The service must ensure persons employed in the provision of a regulated activity received training, professional development, supervision, and appraisal as was necessary to enable them to carry out the duties they were employed to perform (Regulation 18 (2) (a)).

Action the trust SHOULD take to improve:

Royal Stoke University Hospital

- The service should ensure the correct level of harm is reported and reviewed when incidents are reported in line with national guidance (Regulation 17 (2) (b))
- The service should review current safeguarding processes in place to ensure staff complete safeguarding risk assessments at every appointment (Regulation 12 (2) (a) (b)).

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care. In addition, the team comprised of two Midwife specialist advisors and a Consultant Obstetrician specialist advisor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation