Surgery	46.08	28.93
SCSD	43.56	6.61
Women's and children's	21	7

Recommendations

The Trust Board is asked to note:

- Staffing of the wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout December and January have been achieved through the deployment of staff and booking of temporary workforce for short notice absences.
- All areas have experienced levels of challenge as a rapid rise in the levels of COVID patients and COVID related staff absence were experienced.
- There were no patient harms reported for December - January. There has been a decrease in incident reporting over this period of time.
- Workforce plans have been instigated and remain in place to deploy staff to support patient care needs in adult wards and critical care units following the surge in Covid 19 infections.
- The Trust has received support from Health Education England/NHSE/I from bids to support pastoral and educational needs of staff and the recruitment and retention of International Nurses and Health Care Assistance.
- The Trust has received and welcomed 48 third year student nurses into paid band 4 positions for 11 weeks to support patient care wave 3 pandemic following implementation of national NMC Emergency Standards.

Appendices

Appendix 1 Midwifery Safe Staffing Report

Appendix 2 Framework for deploying staff and returning to substantive posts

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 March 2021
Paper number	Enc F1

Midwifery Safe Staffing Report Oct - Nov 2020

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer		
Presented by	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing	**Author /s**	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Maternity Governance	February 2021	
TME	20 January 2021	Report noted

Recommendations	Trust Board is asked to note how safe staffing is monitored and actions taken to mitigate any shortfalls.

Executive summary	A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions: • Completion of the Birthrate plus acuity tool (4 hourly) • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Daily staff safety huddle • COVID SitRep (re -introduced during COVID 19 wave 2) October and November was a challenging period of time to maintain safe staffing levels. Actions taken did provide appropriate mitigation however delays in care were noted and the increased utilisation of the community midwifery team to support the maintenance of safe staffing levels was noted. The directorate has recently recruited into all vacancies and further adverts will be placed to recruit into 10 WTE additional funded posts to support the team during the challenges of COVID. This is expected to have a positive impact on the Directorates ability to maintain above 90% fill rates.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
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Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0	1	2	3	4	5	6 x	7	N/A
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*								

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**3 months**					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 March 2021
Paper number	Enc F1

Introduction/Background

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored to provide assurance.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tool (4 hourly)
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Daily staff safety huddle
- COVID SitRep (re -introduced during COVID 19 wave 2)

The biannual report (published in June and December) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The Trust is required to complete a full Birthrate plus audit in Spring 2021.

Issues and options

Completion of the Birthrate plus acuity tool (4 hourly)

The Birthrate Acuity Tool summary for October – November is presented below and also the documented shortfalls and actions taken to mitigate any risks identified and demonstrate that acuity was higher than the actual staffing in 48% of the time. This % is documented **prior to any actions taken** and it is noted that in the majority of cases this is due to a staff member undertaking scrub duties in theatre. Recent meetings have been undertaken with SCSD to discuss the opportunity to transfer this service and remove the requirement for midwives to scrub in theatre.

The second recorded reason for a shortfall is sickness which is due to both COVID and non-COVID related sickness. Non COVID related sickness is being managed in line with the Trust Policy with the support of HR colleagues.

Monitoring the midwife to birth ratio

The birth to midwife ratio is recorded on the dashboard and monitored at Maternity Governance meeting. The ratio in October (1:28) & November (1:24) was within the agreed midwife to birth ratio as outlined in Birthrate Plus Audit (1:29).

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

No red flags affecting care have been reported via Datix during this time and it has been noted that 'red flags' are poorly reported via this mechanism. Lower than expected staffing levels have been reported. The Directorate has worked with the E Roster team to develop a module within 'Safe care' to record 'red flags'. Training has been arranged for the unit managers to ensure that the flags are recorded consistently.

Daily staff safety huddle

Daily staffing huddles have been completed each morning within the maternity department. In addition to this huddle a second daily huddle (attended by HoM) has been in place when it was noted that minimum staffing levels were not achieved or acuity was high and escalation required. Senior oversight and professional judgement has been utilised to undertake appropriate actions to ensure safe staffing.

COVID SitRep (re-introduced during COVID 19 Wave 2)

The Divisional Management team complete a daily COVID huddle with all directorates to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing and is a forum for Matrons and Ward Managers to raise concerns about staffing levels.

In October staff raised their concerns regarding the level of staff on shift.

Actions taken

The Divisional Management Team met with staff to discuss their concerns and to provide assurance as outlined below:

- It was established that whilst acknowledging expected levels of staffing had not been met on certain occasions, minimum safe staffing levels were achieved and patient safety maintained.
- The increased episodes of escalation and the reliance on support from the on-call community midwife were also acknowledged and staff assured that this was a result of COVID related absence. Daily safe staffing huddles continued to monitor and plan mitigations.
- The delays in Induction of Labour continued in October: each delay was managed through continuous risk assessment with the multi-professional team and some women were transferred within the LMNS supported by Wye Valley Trust.
- No adverse clinical incidents were reported which related to staffing or delays in care however it is acknowledged that some women had a poor experience. Daily discussions with the Consultant / midwife in charge were undertaken and further support offered by the named lead midwife following discharge.
- All non-essential training and non - clinical working days were cancelled and all of the matrons ward managers and specialist midwives were deployed to the clinical areas to support safer staffing levels as required throughout this period.

Conclusion

October and November was a challenging period of time to maintain safe staffing levels. Actions taken did provide appropriate mitigation however delays in care were noted and the utilisation of the community midwifery team to support the maintenance of safe staffing levels was increased and the impact of this was noted.

The directorate has recently recruited into all vacancies and further adverts will be placed to recruit into 10 WTE additional funded posts to support the team during the challenges of

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
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Paper number	Enc F1

COVID. This is expected to have a positive impact on the Directorates ability to maintain above 90% fill rates.

Human resources continue to support ward managers/Matrons to manage sickness absence in line with the Trust Policy.

Recommendations

Trust Board is asked to note how safe staffing is monitored and actions taken to mitigate any shortfalls.

Appendices

Situation report on staffing to meet patient care requirements during wave 3 of the Covid19 pandemic.

Situation nurse staffing required to meet patient demand

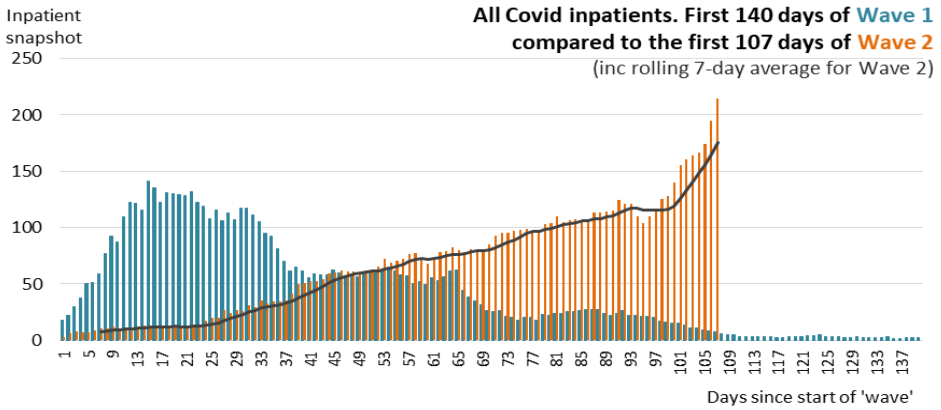
Throughout November and December the number of detected positive Covid patients rose at a steady state.

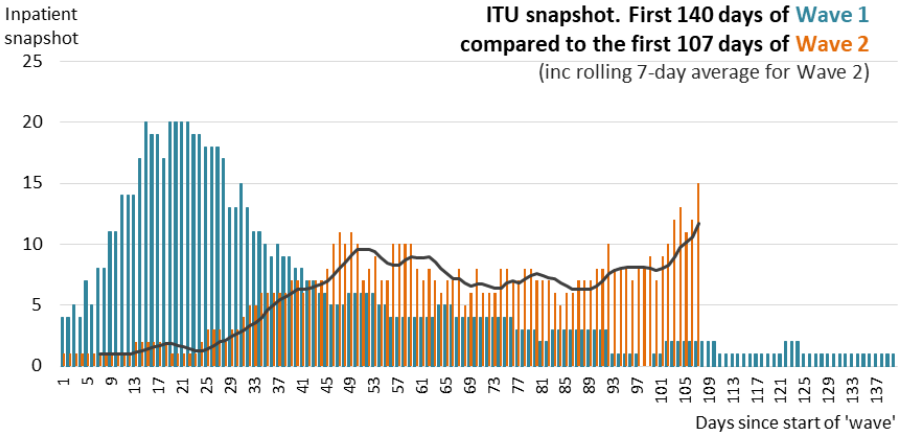
Since 01 January our requirement for staffing Covid beds has increased as demand surged.

This growth of inpatient numbers (Covid-19) has required designation of ward areas to Covid and Non covid to ensure there is the availability of Covid capacity to meet growing need.

Critical care use remained constant throughout November and much of December 2020.
At the beginning of November there was reported an average of 7 Covid patients in ITU across the Trust.

The surge of patients seen from the beginning of January has required a prompt response to redeploy staff to meet patient demand and acuity and increased use of temporary staffing





Redeployment of staff : principles

From January 1st a step by step redeployment of nursing/ allied health care/health scientist staff has taken place of:

1. Nurses who have previous Critical care (CC) experience from wards/departments to critical care.
2. Those non CC skilled staff (nurses/ childrens nurses, physios) to supported blended model* of care in CC.
3. Registered nurses, health care assistance, AHP/ Allied health scientists from base department wards to date.
4. Allied health Professionals/ shielding staff/ health scientists to support family liaison role, Pals and quality improvement initiatives implemented to support patient and carer experiences.

Method of redeployment

- Divisions 'own' and maintain own staffing lists, supported with the implementation of a redeployment hub (clinical and non-clinical) providing a central list and corporate oversight for reporting and recording on a shift by shift basis.
- The redeployment support team update daily requests, identify suitable people for redeployment and signpost / liaise with the relevant Managers.
- The E-rostering team update the e-rostering system on a live basis to ensure full visibility of the roster.

Blended team model of care provision in ITU

Definition of blended team model of care nursing in critical care units
During surge, nursing care can be delivered in a 'Pod' structure,

The CC nurse 'leads' the Pod, and identifies the skill set of any team members who may be:

- • Registered Support Clinicians (RSC) or
- • Non-Registered Support Staff (NRSS)

They then allocate, and supervise where required, tasks according to this.

(London Transformation and learning Collaborative, December 2020)

ITU Trained nurses	ITU experienced nurses to manage patients on a ratio of 1 ITU trained nurse to the equivalent of 2 level 3 patients as part of a blended team approach i.e. support of an RGN/ODP to support as part of a blended team to manage multiple patients. Each patient having one trained professional.
Trained nurses / ODPs (non ITU trained)	RGN or ODP to work as part of a blended ITU team to manage patients. Blended teams will work with a designated ITU trained nurse. Trained nurses and ODPs will need to deliver: • General patient care, including, washing, eye care, pressure care • Recording of obs etc • Checking drugs • Moving patients
Health Care Assistants	Other healthcare works to support blended teams and units with: • General runner and help with equipment • General care needs of patients • Stores Support

Critical Care surge and Super surge plans

Baseline = 12 beds requiring a model where every patient will have one ITU skilled staff to provide care.

This equate to 78 WTE for a County wide rota – 24/7

- A stepped approach to increase the beds required to meet demand has been taken incrementally
- Move from 12 in November 2020 to 32 beds as of 14th January 2021
- This required an increase with implementation of blended team model of care for current 32 beds in operation of 165 WTE - 24/7
- The ratio of nurse to patient has been agreed to change to the below

	27 beds	30 beds	36 beds
Critical Care Patient to ITU trained nurse ratio	1.8:1	2:1	2.4:1

Registered nurses, health care assistance, AHP/ Allied health scientists from base department wards to date.

With redeployment of skilled staff to CC back fill of wards has been instigated with support non ward based staff have been supported and moved to support patient care on wards

To date 54 staff redeployed either in a part time capacity – maintaining critical required aspects of current role or in a whole time capacity

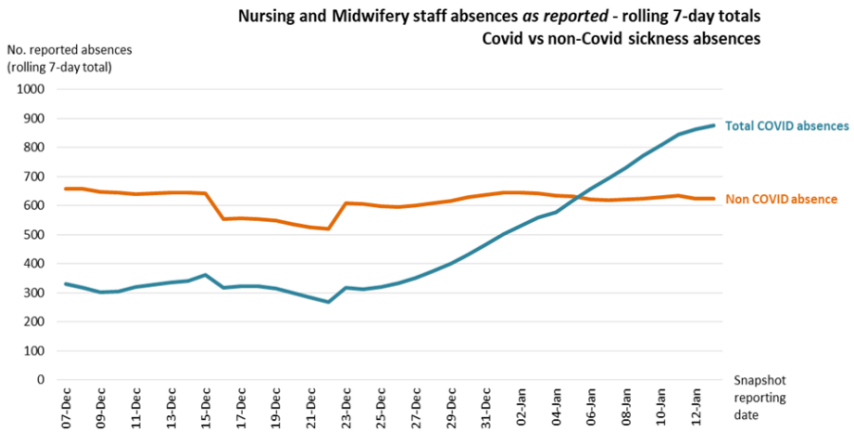
Staffing required to support Quality improvement initiatives implemented to support patient/carer experiences

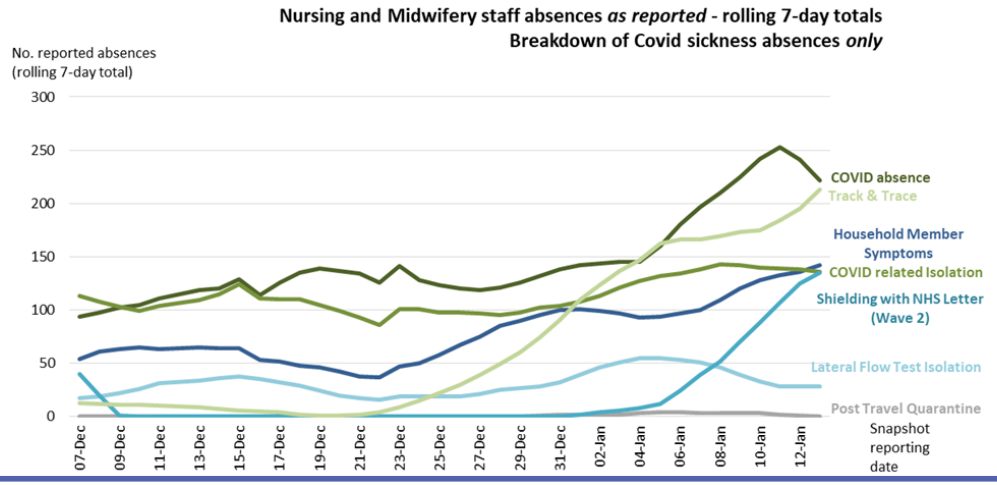
- Family liaison service
- Supporting the single point access phone line for relatives
- Tea/coffee/lunch support for wards
- Patient belongings

- Quality improvement patient/carer initiatives have required the redeployment of clinical staff and non clinical staff

Staff absence

With the increase in community prevalence from Covid 19 infections we saw associated nursing and Midwifery staff absences through December in to January as illustrated in the graphs below.





We have been acutely aware of the fact that staff absences and high acuity, bed occupancy has resulted in a two-fold impact:

- potential impact on quality of care
- potential impact on staff moral, health and wellbeing.

Actions taken:

- re visit staff awareness of the offer for support and to encourage they prioritise their own health and wellbeing offers of flexible working arrangements
- Reinstated use of the dynamic trigger tool in safety huddles with weekly auditing care provision
- redeployment of staff, use of a blended model* of staffing facilitated by buddy system and meet and greet model at start and end of shifts in CC
- Increased visibility of leadership nursing team., reinstated Covid responsive site leadership team

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th March 2021
Paper number	Enc F2

CQC Inspection Report - Maternity, December 2020

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer		
Presented by	Vicky Morris, Chief Nursing Officer	**Author /s**	Siobhan Gordon, Head of Quality Hub & Healthcare Standards

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Trust Board is requested to receive the Care Quality Commission (CQC) report published on 19th February 2021 and to note the associated actions that will be taken in responding to the Must and Should Do's.

Executive summary

During 2020/21, the CQC conducted one unannounced inspection at Worcestershire Acute Hospitals NHS Trust. On 9th December 2020, the CQC conducted an on-site focused inspection of the Maternity Core Service at Worcestershire Royal Hospital.

CQC released their final inspection report to the Trust on 19th February 2020 (Appendix 1). The outcome has resulted in the Maternity service's overall rating reducing from "Good" to "Requires Improvement". The Maternity ratings have been revised as follows:

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Maternity	Requires Improvement →← *Feb 2021*	Good →← *Feb 2021*	Good →← *Sept 2019*	Good →← *Sept 2019*	Requires Improvement ↓ *Feb 2021*	Requires Improvement ↓ *Feb 2021*

This inspection did not include all our key lines of enquiry. As a result of this inspection, CQC rated Maternity "Safe" and "Well-led" domains as requires improvement, and "Effective" domain as good. "Responsive" and "Caring" domains were not included within the scope of this inspection.

The following positive findings were identified:

- ✓ 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.

- ✓ Doctors, nurses and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.
- ✓ The service provided care and treatment based on national guidance and evidence-based practice.
- ✓ The service used systems and processes to safely prescribe, administer, record and store medicines.
- ✓ The service had enough medical staff with the right qualifications, skills and experience to keep women 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 design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- ✓ The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- ✓ Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- ✓ Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.

The CQC identified that further improvements were required within Maternity to ensure:

- Effective monitoring and oversight of staffing.
- Monitoring risks, issues and patient outcomes.
- Incident reporting and sharing learning.
- Engaging with staff to make improvements in a timely way.
- Training compliance post COVID-19 pandemic response.
- Governance processes - staff roles, accessible information.

The Trust has maintained its overall quality rating of "Requires Improvement". Overall Trust ratings are as follows:

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Overall Trust	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th March 2021
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Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF 3930 - IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care & reputational damage.

Assurance Level (x)	0		1		2		3		4	x	5		6		7		N/A	
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Introduction/Background

Between July and September 2020, the CQC received four anonymous whistle-blower enquiries, which were shared with the Trust for review and comment. The whistle-blowers focused mainly on concerns raised by staff regarding staffing levels. In the two weeks prior to inspection, the CQC requested maternity staff rotas and incident reporting information. In addition, four Microsoft Team calls took place between the Divisional Director of Midwifery & Gynaecology Nursing and the CQC relationship manager to discuss staffing concerns.

The CQC carried out an unannounced focused maternity core service inspection at Worcestershire Royal Hospital on 9th December 2020. No safety concerns were raised during or after the inspection. Over the next 5 weeks, the CQC requested 81 data requests and 2 additional Microsoft Team calls took place between the Trust and CQC.

A draft report was provided to the Trust on 20th January 2020 and the factual accuracy process was followed. This process allows the Trust to challenge the accuracy of the draft CQC inspection report. Of the 34 challenges the Trust made regarding factual accuracy, 31 were upheld, 3 were partially upheld.

Following the inspection, the Maternity service's overall rating was reduced from Good to Requires Improvement. The service was rated as Good for being effective and Requires Improvement for being safe and well-led. The service's previous ratings for caring and responsive remained as Good.

The report identified a total of 11 Must Do's and 9 Should Do's. These new Must Do's are as follows:

- There is a process for monitoring if substantive staff working bank shifts worked additional hours to ensure no staff member is working excessive hours. Regulation

Meeting	Trust Board
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17(2)(d).

- The service assesses, monitors and mitigates the risks relating to the health, safety and welfare of service users and others who may be at risk; including ensuring the risk register reflects all risks. Regulation 17(2)(b).
- Staff recognised and report all incidents and near misses; and learning is shared effectively from incidents. Regulation 17(2)(b).
- Senior leaders have oversight of staffing, in order to deal with concerns. Regulation 17(2)(d).
- Their audit and governance systems remain effective. Regulation 17(2)(f).
- The service maintains accurate records relating to the planning and delivery of care and treatment. This includes governance arrangements, audits and meeting records. Regulation 17(2)(d).
- The service monitors the frequency that the escalation policy has been used. Regulation 17(2)(d).
- The service seeks and engages with staff for feedback to make any improvements without delay when they are identified. Regulation 17(2)(e).
- There are enough midwifery staff to deliver safe care and treatment. Regulation 18 (1).
- Staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. Regulation 18 (2) (a).
- Appraisal compliance for nursing and midwifery registered staff meets the trust target. Regulation 18(2)(a).

All new Must and Should Do's will be progressed via the Trust's Regulated Activity Improvement Tool (RAIT) and process.

The CQC have requested an action plan by 19th March 2020 (Appendix 2) outlining actions the Trust will take to ensure the following regulated activities are met:

- Regulation 17 HSCA (RA) Regulations 2014 Good Governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

Recommendations

Trust Board is requested to receive the Care Quality Commission (CQC) report published on 19th February 2021 and to note the associated actions that will be taken in responding to the Must and Should Do's.

Appendices

Appendix 1 - CQC Inspection Report - Maternity	Appendix 2 - CQC Action Plan

Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Inspection report

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

Date of inspection visit: 9 December 2020
Date of publication: 19/02/2021

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Worcestershire Royal Hospital

Requires Improvement 

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

Summary of services at Worcestershire Royal Hospital

Worcestershire Acute Hospitals NHS Trust was established in April 2000 and provides a service across five sites: Worcestershire Royal Hospital (WRH); Alexandra Hospital (AH); Kidderminster Hospital and Treatment Centre (KHTC); Evesham Hospital (EH); and Malvern Community Hospital.

Worcestershire Acute Hospitals NHS Trust provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties. The trust provides maternity services to women living across the county of Worcestershire. Outpatient maternity services are provided on the WRH, AH and KHTC sites. There are also six community midwifery teams and five continuity of carer teams based at various locations across the county.

The maternity service is managed through the trust's women and children's division. The current leadership structure includes a clinical director, a directorate manager, and a director of midwifery. Obstetricians, matrons, and senior midwives also support the senior leadership team.

The maternity service provides consultant and midwife-led antenatal, intrapartum and postnatal care. There are 62 inpatient beds, spread across the delivery suite, the Meadow Birth Centre, and antenatal and postnatal wards, transitional care unit and neonatal unit. Outpatient services include antenatal clinics, a maternity day assessment unit, a triage unit and screening services. Community midwifery services are provided at local children's centres, GP practices or at the patients' home address.

The consultant led delivery suite has nine delivery rooms plus a pool room, two dedicated obstetric theatres and a two-bedded recovery bay for post-operative women. The Meadow Birth Centre is the midwife-led birthing unit and consists of three low-risk birthing rooms each with birthing pools and the dedicated bereavement suite which had a garden area attached.

There is a 14-bedded antenatal ward with six beds for elective gynaecology patients, and a 35-bedded postnatal ward which includes a nine-bedded transitional care unit. The maternity service has an antenatal outpatient department and includes screening services, the early pregnancy assessment clinic and antenatal clinics.

Community midwives provide care for women and their babies both during the antenatal and postnatal period. They also provide a home birth service. The total number of home deliveries for 2020 (January to December inclusive) was 121, 2.5% of all deliveries for the period.

Due to the COVID-19 pandemic there had been changes in the way services were delivered. The Meadow Birth Centre had been reallocated as a specific COVID-19 area for women. There had been no community-based parent education or breast-feeding support sessions in line with social distancing advice. Women were directed to access reputable websites for guidance, or phone the community midwife for advice. The service had also temporarily suspended their tongue tie service.

Our findings

From July 2019 to June 2020 the service reported 4,961 deliveries. This was a 4.5% decrease from the previous 12 months, where 5,195 deliveries were reported.

Activity:

- Caesarean sections rate was 29.9%
- Instrumental delivery rate was 10.7%
- Non-interventional delivery rate was 59.3% (-1.28% compared to the previous year).
- Midwives numbers 203.8 (in post) whole time equivalents (WTE) September 2020. Funded is 213 WTE midwives.
- Consultant obstetricians/gynaecologists numbers: 20.9 WTE September 2020
- There were no never events between December 2019 and November 2020 in maternity or gynaecology (NHS England and NHS Improvement)
- There were no current CQC maternity alerts under consideration by the CQC outliers panel.
- Ratio of births to midwifery staff: 22.4 July 2019 to June 2020.
- Ratio of senior midwives to midwives: 0.21 September 2020
- Four maternal deaths were reported to the Healthcare Service Investigation Branch (HSIB) since the start of 2018 (2 in 2019; 2 in 2020). [July 19, Nov 19, Mar 20, Dec 20]

We last inspected maternity services in June 2018. We rated the service as requires improvement for safe, and good for effective, caring, responsive and well-led. The service was rated as good overall.

During the 2018 inspection, we identified some concerns in the safe domain for the maternity service. These included poor compliance with safeguarding adults and children training for medical staff, maternity specific training compliance that did not meet trust targets; prescription charts were not always completed with patient's weight or allergy status, which was not in line with national standards; poor compliance with cardiotocography trace peer reviews; and not all staff had received an annual appraisal.

We were concerned about maternity services at the trust following four whistle-blower enquiries we received between July and September 2020, and information we received from the trust. Therefore, we carried out an unannounced focused maternity inspection at Worcestershire Royal Hospital on 9 December 2020.

We inspected clinical areas in the service, including the delivery suite, Meadow Birth Centre, ante natal and post-natal wards, the antenatal clinic, and the maternity day assessment unit. We spoke with 19 staff, including service leads, midwives, medical staff, and student midwives. We reviewed 11 sets of patient records and 11 prescription charts and observed staff providing care and treatment to women.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, this did not include all our key lines of enquiry. As a result of this inspection, we rated safe and well-led as requires improvement, and effective as good.

Overall the service was rated as requires improvement.

Our findings

Following this inspection, we issued two requirement notices to the trust as we found improvement was required in several areas. We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Maternity

Requires Improvement  

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

- Not all staff were up to date with their training.
- We were not assured that all medical staff had current knowledge relating to Mental Capacity Act 2005 and Deprivation of Liberty Safeguards due to poor training compliance.
- Risk to women was not always identified appropriately. Staff did not always complete and update risk assessments for each woman or act to remove or minimise risks. Staff did not always identify and act quickly when women were at risk of deterioration.
- Whilst staffing levels were often lower than planned, managers regularly reviewed and adjusted staffing levels and skill mix. Actions were taken to meet patient acuity, however, these were not robustly documented. Staff were redeployed within the unit when needed, to keep patients safe from avoidable harm and to provide the right care and treatment but records of this were weak.
- The service did not always manage safety incidents well. Staff recognised but did not report all incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, staff did not always have time to check emails to find updated incident information. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff did not always monitor the effectiveness of care and treatment. When care and treatment was monitored, they used the findings to make improvements and achieved good outcomes for women.
- Training compliance had fallen during the COVID-19 pandemic but a plan was in place to improve this. However, the service generally made sure staff were competent for their roles.
- Although leaders mostly had the skills and abilities to run the service and understood the priorities and issues the service faced, they did not always take timely action to address the concerns identified. They were visible in the service for women and staff.
- Staff did not always feel respected, supported and valued by all managers. They were focused on the needs of women receiving care. The service did not have an open culture staff felt they could raise concerns without fear.
- Although leaders and teams used systems to manage performance they did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. They did not have plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid potential financial pressures compromising the quality of care.
- Whilst governance processes were in place leaders did not always operate these effectively throughout the service. Leaders liaised with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not all have regular opportunities to meet, discuss and learn from the performance of the service.
- The service did not always collect reliable data and analyse it. Staff could not always 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.
- Leaders did not always engage with staff effectively. However, staff actively and openly engaged with women, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

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- Although all staff were committed to providing good quality care timely action was not always taken to improve.

However:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- 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 service had enough medical staff with the right qualifications, skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Directorate managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.
- 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.

Is the service safe?

Requires Improvement 

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

Mandatory training

Not all staff were up to date with their training.

The trust set a target of 90% for completion of mandatory training. The 90% target was not met for mandatory training modules for the qualified midwifery staff eligible. Data provided by the trust demonstrated that at 31 March 2020 midwifery staff were 83% compliant with mandatory training and at 30 November 2020 compliance was 75% overall. Medical staff compliance was 84% at 31 March 2020 and 76% at 30 November 2020. Managers had not identified individual training modules to clarify areas where there was greater or worse compliance. Managers told us during our focused inspection that compliance for mandatory training as at November 2020 was 30% for maternity support workers, 35% for midwives, 33% for medical staff and 26% for anaesthetists. This was compared to a compliance of 90% in 2019. Further information was requested from the trust to identify training data for specific topics for both medical and midwifery staff. Data provided by the trust showed that of the 14 mandatory training modules for which maternity and medical staff were eligible maternity staff were not fully compliant in seven of the modules in March with an overall

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compliance of 83%. In November 2020 compliance was 76% overall with 11 of 14 modules not meeting the 90% target. Medical staff did not meet the target in any of the 14 modules in March or November 2020 with an overall compliance of 78.19% in March and 72.83% in November 2020. Due to COVID-19 face to face mandatory training courses had not taken place since March 2020. Mandatory training compliance was discussed at divisional governance meetings. The November 2020 minutes noted that mandatory training compliance had decreased to 79.64% in October 2020. Clinical educators had instigated an online training package to support and encourage staff to complete mandatory training components. This was reported to have generated positive feedback from staff. Plans were in place to resume training with staff booked onto courses until July 2021.

In addition to the trust's mandatory training, maternity staff attended a multidisciplinary training course, which covered an annual PRactical Obstetric Multi-Professional Training (PROMPT) style 'skills and drills' training. As at March 2020, 80% Anaesthetists, 68% Doctors, 60% Midwives, 78% Maternity Support workers had completed skills and drills training. This did not meet the trust target of 90%. PROMPT had been cancelled due to COVID-19 from March 2020. The skills and drills training figures for November 2020 were 26% Anaesthetists, 33% Doctors, 35% Midwives, 30% Maternity Support workers. However, training had been recommenced during the summer months with reduced numbers of staff attending sessions to comply with social distancing guidance. A plan was in place from September 2020 to ensure full compliance by July 2021.

The service had systems in place to assess and monitor staff competency in relation to cardiotocography (CTGs). Staff were required to complete annual 'K2 training', which was an online training system for performing, reading and interpreting CTG outputs for women and were assessed for competency on completion of the complete package. Compliance for midwives was 87% in February and 63% in December 2020. For the same period medical staff compliance was 67% and 87%. These figures did not meet the trust target of 90%. During our June 2018 inspection, maternity specific training compliance, such as CTG training did not meet the trust target. We requested data from the trust to identify how the risk of low training rates was mitigated. Managers provided information to identify the training provided with planned reduced attendance figures to accommodate social distancing. The maternity training team were visible throughout the service to encourage all staff to utilise the electronic systems for training. A peri-mortem caesarean section presentation was delivered to staff at handovers. Staff meetings and maternity training updates were circulated at effective handovers and on a social media platform. Live skills and drills were planned to occur monthly or more frequently if possible.

A seven-month plan was in place to ensure 90% compliance for training. All external study leave was to be declined if either PROMPT or CTG training had not been completed. In the event of a third wave of COVID-19, PROMPT was to be delivered through online platforms.

Training completion was monitored electronically, and staff received reminders to complete training. However, training compliance in most topics did not meet the trust target. Therefore, we were not assured that training was prioritised. Staff told us training was often cancelled due to low staffing levels. Staff also reported completing mandatory training in their own time due to clinical pressures.

Safeguarding

We were not assured that all medical staff had current knowledge relating to Mental Capacity Act 2005 and Deprivation of Liberty Safeguards due to poor training compliance. Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

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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. The trust had a named lead midwife for safeguarding who provided support, supervision, and updates to staff. Safeguarding policies and clinical pathways were in-date and were accessible to staff via the trust's intranet. Processes were in place to identify adults and children who were at risk of harm in paper and electronic maternity records. However, we saw that there were occasions when safeguarding information had not been transferred to community staff on discharge from the department or safeguarding information transferred to the babies' record. This was addressed through safeguarding supervision with midwives.

Staff received training specific for their role on how to recognise and report abuse. The trust set a target of 90% for completion of safeguarding training. Maternity staff met the trust target for one of the three safeguarding modules. However, level 2 children's safeguarding training compliance did not meet the trust target for medical staff for March 2020 at 75% and 69% for November 2020. Medical staff low compliance with adults and children's safeguarding training was a concern identified at our 2018 inspection. Maternity staff met the trust target at 94% for March 2020 but demonstrated 86% compliance in November 2020. Level three children's safeguarding training met the trust target at 95% in March 2020 and met the target for November 2020. The number of staff eligible for level 3 adults safeguarding training was 20 (midwives, senior midwives & managers). Staff met the trust target at 95% for March 2020 and 90% at November 2020. Managers told us that work was ongoing with the safeguarding lead midwives to improve compliance with training.

During our 2018 inspection, most staff had not completed the appropriate level of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training. We saw that compliance for midwives for level 3 MCA/ Deprivation of Liberty Safeguards training met the trust standard in March 2020 but was 83% in November 2020. Medical staff compliance for level 2 training was reported at only 48% for March 2020 and 52% for November 2020. We were not assured that all medical staff had current knowledge relating to MCA and Deprivation of Liberty Safeguards. Following our inspection, we requested data from the trust as to how compliance was to be increased for medical staff. Managers told us that mandatory training was emphasised regularly at all departmental and divisional meetings. In addition, in order to be able to apply for study leave, all staff had to be fully compliant with mandatory training which included MCA/DOLS. Additionally, the division undertook regular monitoring of mandatory training compliance using the regulated activity improvement tool process.

The labour ward and delivery suite posed a risk for baby abduction. Most staff were aware of the baby abduction policy but there were no baby abduction drills included in maternity specific training. This meant some staff may not know what to do in such circumstances. Managers told us that abducted baby procedures would be included in the next skills and drills courses.

Babies wore electronic tags. An alarm rang throughout the hospital if a baby left the ward with their tag in place. Staff were aware of actions to take and security staff arrived on the ward in the event of a possible baby abduction attempt. Staff told us that sometimes babies left the unit with tags in place. Concerns had been raised by managers about the reliability of the system which included alarming, lack of location identified and a delay in the resetting of the system- the time lag. Additionally, managers had identified there was no programme of recording drills and incomplete training of all staff who would be involved. This was recorded on the risk register. Closed circuit television (CCTV) was available throughout the maternity unit. Following our inspection, we requested the action plans for the management of the baby tag system

There were processes in place to allow entry and exit to the delivery suite and postnatal ward. We observed visitors to the ward were required to be let into the ward through a secure door buzzer that staff operated. Cameras were situated

above all entrances and could be observed from the ward desk areas before entry was allowed to the department. Following our inspection, we asked whether staff maintained a list of people not allowed to enter the clinical areas for safeguarding reasons. Managers told us that processes were in place to identify any individuals who posed a risk to women and babies. Information would be documented in the birth plan and shared through safeguarding documentation and alerts on the hospital electronic records systems where red flags would identify any risks. Managers reported that the recently introduced electronic system enabled red flags to be created against specific records. Each ward was locked and had intercom/bell access only. Support to remove those who were not allowed to visit was sought from the security team on site and escalated to the police as required.

Cleanliness, infection control and hygiene

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

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. Staff followed infection control principles, including the use of personal protective equipment (PPE). The service followed current guidance for infection prevention and control when assessing and caring for women with possible or confirmed cases of COVID-19. The meadow birth centre was used specifically for women with possible or confirmed cases of COVID-19. This included an area for ante-natal appointments and scans for women with possible or confirmed COVID-19.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping staff cleaned wards and public areas, in accordance with daily and weekly checklists. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw completed and signed check lists for November and December 2020.

Staff adhered to the trust's 'bare below the elbows' policy to enable effective hand washing and reduce the risk of spreading infections. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public. Infection prevention and control audits were completed within the maternity service. The audits included, but were not limited to, hand hygiene compliance, equipment cleaning, and compliance with the daily tap flushing schedule (completed to prevent infection, such as Legionella, from thriving). The band 7 midwife received a message on an electronic application when all checks were completed. From September to November 2020 all maternity areas scored 100% in the monthly hand hygiene audit. For the same period, maternity areas scored between 89.8% and 100% in their cleaning audits.

Women were screened for MRSA in line with guidance. Where inpatient women had a known or suspected infection, they were cared for in single side rooms. There had been no cases of *Clostridium difficile* or MRSA bloodstream infections in the maternity service from December 2019 to November 2020. Processes were in place to screen women for COVID-19 three days before planned attendance. Any women who tested positive were treated in the meadow birth centre. All visitors to the clinical areas had their temperatures taken to ensure they were within normal limits.

Signage was evident throughout the department both on the walls and with floor markings to remind staff, women and visitors to wash their hands, maintain social distance and keep to the left-hand side of the corridors in line with national guidance.

Environment and equipment

Maternity

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 service had suitable premises and equipment to care for women and babies and keep them safe. Treatment and clinical rooms were clean, uncluttered, and organised. However, some corridors were cluttered with equipment but were passable with a bed.

The service had access to two obstetric theatres and a recovery area. The neonatal unit was close by if a baby's condition deteriorated and required an urgent transfer. The transitional care unit was also easily accessible.

The service generally had enough suitable equipment to help them to safely care for women and babies. However, some staff reported that it could take a long time, around 15 minutes, to find equipment for example syringe drivers and sonnicaids. This meant that there was a potential delay to commencing treatment. No incidents were reported about poor access to equipment from July to October 2020. Following our inspection, we requested information from the trust regarding the management and allocation of equipment. Managers told us that each ward had an equipment list that was monitored by the housekeeper. Equipment was serviced and repaired by the manufacturer or in house. Housekeepers audited equipment availability against the list and ordered equipment with the support of the ward manager. We saw that equipment assets documents were maintained and included dates when maintenance had been undertaken.

Equipment had up to date safety testing, including resuscitaires, defibrillators, blood pressure machines and a blood gas analyser. There were processes in place to ensure equipment was checked daily. Staff carried out daily safety checks of specialist emergency resuscitation trolleys, defibrillators, suction equipment and resuscitaires. Equipment was checked and disposable items were in date. The band 7 midwife received a message on an electronic application when all checks were completed. We reviewed daily checklists for the emergency equipment from 1 November to 9 December 2020 which were all completed.

Staff managed clinical waste well. Staff disposed clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Arrangements were in place for the Control of Substances Hazardous to Health. However, we saw that cleaning equipment was not always stored securely in locked cupboards. For example, not all sluice doors had key pad locks to prevent unauthorised access. We saw that the sluice door on the labour ward was propped open with hand gel, soap lotion and cleaning fluid was easily accessible. The labour ward co-ordinator was informed and took immediate action to ensure the environment was safe.

Assessing and responding to risk

Risk to women was not always identified appropriately. Staff did not always complete and update risk assessments for each woman or act to remove or minimise risks. Staff did not always identify and act quickly when women were at risk of deterioration.

The service had a formal triage centre but did not always have designated medical staff allocated to the area. Due to the COVID-19 pandemic and some gynaecological elective surgery being cancelled, doctors were allocated on some occasions. Staff reported that they could be busy covering all areas, especially at times of high acuity. However, medical staff told us that there was a very clear trigger list for consultant attendance and presence.

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The service used the Birmingham Symptom Specific Obstetric System (BSOTS). The system involved completion of a standard clinical triage assessment by a midwife within 15 minutes of a woman's attendance to define clinical urgency, guide timing of subsequent assessment and immediate care. We reviewed 11 patient records and 14 episodes of care. In eight cases (57%) women were seen in an appropriate time frame, one woman was not seen within 15 minutes and four records (28%) were not completed. Following our inspection, we requested triage time audit data. A June 2020 audit of women in triage, saw that 82% of women had an initial assessment and fetal heart auscultation within 15 minutes. The trust set a target of 100%. However, only 40% of women were reviewed by a doctor within the correct timeframe. In addition, the audit identified that 77% of women had the correct BSOTS colour codes applied, 44% of paperwork was completed accurately and the timescale of arrival to fetal heart monitoring within 15 minutes was 70%. Fetal heart was auscultated and documented in 100% of cases. Following the audit several recommendations were made. These included relaunching BSOTS with additional training, randomly sampling 10 records each month, assigning a doctor to the rota for triage in line with BSOTS recommendations, holding regular team meetings to discuss concerns, reviewing the triage referral policy, reviewing staffing and re-auditing in January 2021 following the relaunch of BSOTS. Divisional managers had planned a meeting with staff for September 2020 to discuss the concerns identified within the audit. However, the meeting was cancelled due to poor attendance, no date for the meeting to be rearranged was provided. Managers told us that the triage and day assessment unit had group electronic applications where information was shared.

Whistle-blowers reported that there were delays in induction of labour with some women waiting up to a week instead of one to two days. Managers told us that there had been delayed inductions of up to six women. Managers told us that women were risk assessed by the obstetric lead if induction was delayed. Following our inspection, we requested additional information from the trust. Induction rates were monitored through the dashboard and reported to the local maternity and neonatal system. Managers did not capture data regarding the length of time women waited for an induction. The time between admission and starting induction of labour was not captured by the trust. Managers reported that measuring delays in induction may be possible with the new electronic records system. Managers told us that the induction of labour rate was higher than expected and trust guidance was being reviewed. Managers had re-instated the labour ward forum where the induction process and guidance was discussed. The maternity voices partnership attended this meeting. Managers were raising awareness around incident reporting and had a trigger list to encourage increased incident reporting. One of the triggers was related to delays in care. Delays in care were escalated in accordance with the escalation process. Managers had undertaken an induction of labour audit in February 2020. The audit concentrated on obtaining an overview of the clinical demographics of women, to identify if induction was aligned to local and national guidance, to compare outcomes and to review decision making processes. The audit identified that pre-induction counselling and documentation was inconsistent, the trust guidelines were unclear regarding gestational diabetes and the most common reason for induction of labour was reduced fetal movements. Recommendations for improvement were made including reviewing trust guidelines, involving a consultant in induction decisions for decreased fetal movements and improving documentation and information provided to women prior to consent.

The service did not always adequately risk assess all women in the ante-natal unit. The service used nationally recognised tools to identify women at risk of deterioration, such as the 'Modified Early Obstetric Warning Score' (MEOWS). However, we reviewed 11 patient records containing 14 episodes of care. Only three (21%) of MEOWS assessments were fully completed. In 79% of assessments respiratory rate and oxygen saturations were not recorded. Pain assessments were not completed in three out 14 episodes of care and fetal movements were not recorded in two episodes of care. Therefore, women were at risk of not being identified if they were deteriorating and needed more frequent observations or immediate escalation to medical staff. Following our inspection, we requested MEOWS audit data. Managers told us that MEOWS audits had not formed part of the audit profile for maternity services during the previous 12 months. The implementation of the new electronic system would allow it to be added to the audit schedule.

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The service also used the "Worcestershire Obstetric Warning Chart" (WOW) to identify women at risk of deterioration. We reviewed three electronic records and saw that these were all fully and accurately completed.

Staff completed booking risk assessments for each woman at their initial booking appointment, which included social, medical and obstetric assessments. This enabled staff to decide if the woman was a high or low risk pregnancy.

We were not assured that swabs used for vaginal birth and perineal suturing were always counted for completeness, in line with national recommendations National Patient Safety Agency (NPSA) reducing the risk of retained swabs after vaginal birth and perineal suturing. We reviewed 11 records and saw there was no information recorded. Following our inspection, we requested vaginal swab audit data. Managers told us that during the last 12 months, the swab audits had not formed part of the audit profile for maternity services. Managers reported that the recent implementation of an electronic records system would allow for an audit schedule which would include swab audits. Managers did not supply information as to when these audits would be commenced, or any actions taken to ensure swabs were counted by two staff.

Carbon monoxide screening, which was part of the 'Saving Babies' Lives 2016' initiative had been suspended since COVID-19. An audit of 80 records undertaken in September 2019 demonstrated that there was 79% compliance against an overall trust target of 100% of all women tested on booking. Compliance for smokers was 88%, however, only 19% of all women were retested at 36 weeks. An action plan was in place for ongoing training of midwives to meet the trust target of 100%, compliance at the time of audit was only 75% overall.

Staff completed venous thromboembolism (VTE) assessments in line with service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein. Of the 11 records reviewed, this was assessed in all cases (100%). However, audit data identified that compliance did not always meet the trust target of 95%. For September, October and November 2020, compliance with VTE assessments was 93%, 87.02% and 89.35% respectively. VTE assessment compliance was discussed at divisional governance meetings. Managers reported that following the introduction of the electronic record system in October 2020 compliance with VTE should improve.

Women with high-risk pregnancies, for example, due to a multiple pregnancy, diabetes, pre-eclampsia and obstetric cholestasis, were regularly monitored and reviewed by an obstetrician. Women who were at high-risk of gestational diabetes were also referred for glucose tolerance testing.

The service had processes for monitoring cardiotocography (CTG). A buddy system was in place for review of CTG interpretation, with guidance for escalation if concerns were raised. This was in line with national recommendations (NHS England Saving Babies' Lives: A care bundle for reducing stillbirth, 2016). The delivery suite used the 'fresh eyes' approach to CTG interpretation and classification. Since September 2020, the service had set a criterion for a "fresh eyes" review at one hour. This meant a second midwife was required to review the CTG recording during labour, to ensure it had been interpreted correctly and appropriate actions were taken when indicated. The on-call obstetric team reviewed the CTG traces of all patients who had continuous electronic fetal monitoring during ward rounds. We reviewed five patient records, with 28 episodes of care. Nine CTG's (32%) were reviewed within 30 minutes, seven (25%) were undertaken within one hour, one (3.5%) was undertaken in over two hours and one entry was omitted. Managers audited "fresh eyes" compliance annually. The last audit in June 2019, demonstrated hourly reviews of CTG took place in 69% of cases, two hourly review was undertaken in 78% of cases with appropriate escalation in 92% of cases. Managers reported that greater compliance could be achieved following the full implementation of the electronic records system. An action plan was developed following the audit to include a policy change to reflect hourly reviews, input from the fetal well-being midwife and a re-audit was planned for January 2021.

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Weekly CTG meetings were held. This was an open forum to discuss and share learning. Staff told us that these were helpful. Staff could review CTG's with consultants and escalate concerns easily. There was no set agenda or documented attendance for these meetings.

The division was practicing outside the trust reporting process for sepsis six audit data. This had been acknowledged within the division and escalated accordingly. Work was ongoing with the associate divisional director for governance and the trust sepsis lead. Managers reported that the implementation of the electronic record system within maternity services would allow for an audit schedule to be conducted, which included sepsis audits. Managers told us that during the last 12 months, sepsis audits had not formed part of the audit profile for maternity services. Managers had added this to the risk register in March 2018. This was monitored at divisional level, then escalated through the risk management group and clinical governance group. Therefore, we were not assured that there was enough oversight of women at risk of developing sepsis.

Managers were not auditing swab counts following vaginal or instrumental births. Swab audits had not formed part of the audit profile for maternity services. Managers told us that the implementation of the electronic records system would allow for an audit schedule including swab counts to be conducted. We were not assured therefore, that all swab counts were accurate and that women were potentially at risk of retained swabs.

We observed the 7.30am midwifery hand over and the 8am multi-disciplinary team (MDT) shift handover meetings. To facilitate social distancing, the midwifery handover took place in a waiting area that was currently closed to the public. All women were discussed so that midwives knew about all women and not just those they were individually looking after. We saw that a "situation, background, assessment and recommendation (SBAR) tool was used effectively and staffing was discussed.

The MDT handover was attended by the co-ordinator, ante-natal and post-natal ward leads, the day medical team, night medical team, neonatal intensive care (NICU) sister and the anaesthetist. However, we saw that some staff arrived 15 minutes late and there were two interruptions. We saw that women's names were used, triage ladies were discussed and there was a review of NICU beds, staffing acuity and risks were discussed. Effective multi-disciplinary discussion was held. Although the SBAR was used, we saw that sometimes SBAR recommendations were not made. For example, following the handover of a premature baby there was identification that steroids had not been given but no plan was made. This meant that there was a risk of omissions of treatment being given.

The service held a daily local maternity system meeting with a neighbouring trust. These meetings had been commenced in March 2020 as part of the local maternity and neonatal system to provide mutual support, discuss staffing, acuity, bed availability and the ability to help as necessary. However, neither the attendance nor discussion was documented. This meant that there was no documented evidence of trends or concerns.

The maternity service used an adapted version of the World Health Organisation's (WHO) Surgical Safety Checklist. This was in accordance with national recommendations (NPSA 'Patient safety alert: WHO Surgical Safety Checklist, January 2009). The checklist was used for women having a caesarean section or other surgical procedure relating to childbirth. Completion of the checklist was audited. Compliance between April and June 2020 was 100%. However, compliance with the team debrief between October and November 2020 was 66.67%, although all other areas were 100% compliant. This meant the service could be assured that the team worked well together to keep women safe from avoidable harm.

Midwifery staffing

Maternity

Whilst staffing levels were often lower than planned, managers regularly reviewed and adjusted staffing levels and skill mix. Actions were taken to meet patient acuity, however, these were not robustly documented. Staff were redeployed within the unit when needed to keep patients safe from avoidable harm and to provide the right care and treatment but records of this were weak.

The service was staffed in accordance with Birthrate Plus, a national acuity tool, to assess staffing requirements based on women's needs. Managers told us that the Birthrate Plus acuity assessment was undertaken in 2019 and was based on 5,500 births per year. Managers told us that they were fully staffed according to Birthrate Plus. The number of births was now 5,000 per year but staffing numbers had not been further decreased since the changes were made in 2019 following completion of the Birthrate Plus desktop exercise. Birthrate Plus is recommended by the Department of Health, endorsed by the Royal College of Midwives, and incorporated within the standards issued by NHS Resolution. The service had introduced the Continuity of Carer (CoC) model in March 2019 and had gradually introduced teams from the staffing establishment. CoC is recommended in the Better Births 2017 report to ensure safer care and better outcomes for women and babies.

Between July and September 2020, we received four whistleblowing enquiries relating to maternity services. Staffing levels were the main area of concern reported. The whistle-blowers reported the introduction of the CoC model had negatively impacted on staffing levels,yet was a management priority. We spoke to staff of all disciplines throughout the unit who unanimously raised concerns about safe midwifery staffing levels and reported they did not feel their concerns were always considered by managers. Midwives told us that the service was always short staffed and that they were moved frequently within the department. We had concerns about planned staffing levels throughout the unit.

Following the four whistleblowing concerns, managers had instigated meetings to listen to staff concerns and take actions to address them. A further planned introduction of another CoC team in December 2020 had been deferred until 2021 as new staff were expected to start in December and were delayed until January 2021.

Managers told us that staffing rosters were completed six weeks in advance allowing escalation of shifts that were not filled. We saw that the off-duty rota allocated shifts did not align with the planned figures provided by the trust. Managers reported there were times when the service were not meeting patient acuity. The planned figures did not appear to include annual leave, those self-isolating, sickness or maternity leave. We noted that between 13 and 15% of midwives were able to work remotely but not clinically due to COVID-19 shielding, were not included in the information. The processes for filling these was that staff were redeployed within the service and local bank was used when needed to keep patients safe from avoidable harm and to provide the right care and treatment. Short term absences identified through the daily roster review were mitigated through review of women's acuity and capacity, the reallocation of staff to high acuity areas and back fill with staff who were working non clinically, for example specialist midwives and ward managers. Additionally, five midwives were rostered over a 24-hour period on an on-call basis from the CoC teams. A further four midwives from the traditional community midwifery team was also utilised should the acuity outweigh the fill rate. In addition, there were staffing shortfalls due to midwives scrubbing in theatre, which may occur for one hour.

Of the rota's received there was no indication as to the grade of staff on duty. From March to June 2020 data demonstrated that there was a shortfall of up to 30% of staff during this period and up to 49% in the period September to December 2020. From 7 October to 25 November 2020 fill rates for registered staff were between 70% and 72% for day shifts and 80% to 94% for night shifts. Fill rates for unregistered staff were between 55% and 70% for day staff and 80% to 97% for night staff. Following our inspection, managers told us that the data represented the staff roster but did not represent the mitigations that were put in place on a shift by shift basis. Managers told us that the health roster had a

high complement of senior skilled staff, with most midwives being at a band six competency level. The trust had a small number of junior band five midwives who were always on shift with more senior staff. Managers reported that there was a 100% registered midwife skill mix. The unregistered nursing workforce was at band two level and was not counted as part of the patient delivery ratio.

Managers told us that the data taken from the health staffing rosters which provided the fill rates, did not prospectively capture the back fill when mitigation was in place. Although mitigation could be captured as narrative through the Birthrate Plus acuity tool, managers acknowledged that this was not done robustly or routinely.

The Meadow Birth Centre had been converted in March 2020 to a COVID-19 cohort unit, staff from the centre had been redeployed to the delivery suite to support staffing levels. Staff were only allocated to the COVID-19 cohort area when a suspected/positive COVID-19 woman was admitted. However, the narrative of these staff moves as a consequence, was not documented.

Managers told us that they used bank staff but did not use agency staff. Managers did not use agency staff even if shifts were uncovered as they reported that it was not safe practice to do so. This meant that some shifts remained unfilled. It was not clear from the data and off duty rotas whether gaps were filled by bank staff or if they were left unfilled. There was no clear process for monitoring if substantive staff working bank shifts worked additional hours. We were therefore, not assured that some staff were not working excessive hours. Managers told us that community midwives logged all call-outs to homebirths and time spent in the unit following the inaction of the escalation policy. Although this identified when staff were called to home births there was no information provided about how collective working hours were monitored to ensure staff were not working excessive hours.

We asked managers how they were reassured that staffing levels were appropriate. Managers told us that assurance was gained using the staffing standard operating procedure in place. An escalation process was in place on each shift where a review was undertaken if a fill rate had not been met. Concerns were escalated to the matron. If, following mitigating actions concerns remained unresolved there was further escalation to the head of midwifery and onto the chief nursing officer as required. However, the number of times and reasons the escalation policy was implemented was not documented or monitored. Therefore, we could not establish how often staffing levels became an escalation issue and there was a risk the service could not learn from previous issues to improve the service.

The escalation policy included the deployment of midwives from other areas and/or specialist roles, to support the unit when needed. A senior member of staff (band 8A or above) was on-call out-of-hours, seven days a week, to support effective working and patient flow within the unit. One band seven was on the rota as part of a development programme and was assigned a “buddy”. Staffing levels were displayed on boards in the clinical area. However, the information provided was inconsistent with some boards displaying planned and actual staffing and others displaying planned figures. Following our inspection, we discussed this with senior managers who reported that the templates would be adapted to ensure clarity of actual and planned staffing.

During the day, a senior midwife was designated as the unit coordinator. They were responsible for managing any issues within the unit, such as staffing and activity. This meant the delivery suite coordinator could focus solely on managing activity on the delivery suite.

Managers monitored staffing shortage red flags. Staffing shortages were meant to be reported on the internal incident reporting system. However, staff told us that they did not have time to report incidents and assumed that senior staff would do it. This meant that not all staffing incidents were reported.

Maternity

Managers told us that maternity staffing levels were discussed at all safety huddles. Additional safety huddles were called as required. The director of midwifery attended the safety huddle if an escalation occurred. The bleep holder managed the daily staffing which included the deployment of staff across the department to manage mitigations, escalations and review prospective staffing rotas. We saw staffing was discussed at safety huddles and bank staff were requested.

Midwifery recruitment had taken place. The service had 5.8 whole time equivalent vacancies which were recruited to in October 2020. Two additional matrons had been recruited, one for the hospital site and one for the community and Continuity of Carer teams. One of these matrons was due to commence in post in January 2021. Staff told us that as a result the presence of managers was improving.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience to keep women 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.

Medical staffing levels within the unit were generally sufficient. The service had 24-hour on call consultant cover. Each consultant was on call once per month. Cover was from 8am to 9pm on site and 9pm to 8am off site. The service had 20 consultants, four of whom were purely obstetricians, two were purely gynaecologists the other 14 covered obstetrics and gynaecology. Consultants worked one weekend in 20 and one Friday in 20. There was a clear trigger list reported for attendance overnight. Medical staff would discuss concerns with the on-call consultant via telephone, who would attend if needed. Consultants did not undertake any operative procedures the day following being on call. However, the cover provided by consultants was not aligned to the labour ward alone. This included covering the gynaecology ward, gynaecology theatres, the emergency gynaecology clinic and taking calls from GP's out of hours and urgent and emergency care. There was not always a dedicated doctor allocated to triage or the day assessment unit. However, medical and maternity staff told us that, due to the cancellation of some elective surgery due to COVID-19, doctors had been allocated to these areas on some occasions. This was dependent on staffing levels, as medical staff would often be busy covering all areas, especially at times of high acuity.

The service had two consultant anaesthetists on duty from 8am to 6pm on site and from 6pm to 8am off site. Senior anaesthetists who were not yet consultants but who had passed their obstetric competencies provided cover at night. A third, more senior anaesthetist was also always available to provide advice and support.

Junior doctors told us that their training and learning experience was positive and there were no gaps in the rota. Consultants were approachable and supportive and medical staff told us they had access to clinical supervisor meetings. Junior medical staff told us that they could escalate concerns easily and received support and advice. All medical staff had undergone an induction programme.

Records

Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.

Staff kept records of women's care and treatment. The maternity service used a combination of paper-based and electronic records. We reviewed 11 sets of paper records. Risk assessments were not fully completed in eight records and signatures were illegible in three records. Following our inspection, we requested record keeping audit data. Managers

told us that maternity notes were not included in the corporate audit tool due to the differences in their records. The maternity unit had not included a health records audit within their audit schedule for 2020/21 or 2020/19 as they were using an electronic system. Locally, the division had conducted quality checks, which included a weekly audit of maternity medical notes, based on 15 sets of case notes. Due to the trust COVID-19 response, the audits were paused in March 2020, and were due to be reinstated in January 2021 at the earliest. However, quality data for December 2019 to March 2020 demonstrated that there was variance in all areas regarding some areas recorded against a trust compliance of 100%. For example, weight was not accurately recorded on the medicines chart in 60% to 70% of records audited, compliance with carbon monoxide monitoring was 20% to 80% on the antenatal and postnatal ward. Other metrics, including completion of the Worcestershire obstetric warning (WOW) chart were 100% compliant.

An electronic records system had been introduced in October 2020. Prior to the introduction staff had received training in the new system. Following the system introduction, managers had introduced "floor walkers" to support staff. Similar support was also available for community staff. Staff told us that the "floor walkers" had been very helpful. The introduction of the new digital record meant pregnant women could access a real-time summary of their maternity notes through an innovative maternity application which had replaced paper records. It also meant information could be shared directly with expectant women from the maternity system. Women could add personalised information for example, plans and preferences for birth which could be discussed with their midwife. The app could be used on their smart phones, tablet device or personal computer.

Women's records were stored securely in lockable trolleys within the enclosed midwives' station on the maternity wards. We saw that computer screens were closed when not attended. Staff had password access to electronic systems.

Discharge summaries were sent to health visitors and GPs. The summary included information about the woman's pregnancy, labour and postnatal care, any medications they had been prescribed, and any ongoing risks and/or follow-up care needed.

The personal child health record (also known as the 'red book') was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

Medicines

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

The service used systems and processes to safely prescribe, administer, record and store medicines. Medicines were stored securely in all clinical areas we visited. Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day. Because of the re-use of the Meadow Birth Centre for women with possible or confirmed COVID-19, the controlled drug cupboards were moved into clinical rooms. Managers told us that permission had been sought from the pharmacy department as the controlled drugs were stored in clinical rooms. Managers told us this was recorded on the risk register. Following our inspection, we requested the risk assessments undertaken. Managers told us that at the onset of wave one of COVID-19, it was identified that the clinical room was shared with the Meadow Birth Centre. As the Meadow Birth Centre was designated the "red" area for maternity COVID-19 women, the ward and triage areas could no longer share the clinical room and the medicine cupboards needed to be relocated. The medicines were relocated to a clean utility room within the triage area, with support from the pharmacy department. An additional controlled drug cupboard and drug fridge

were purchased. The intention was for the new controlled drug cupboard to be installed within an existing drug cupboard within that area. However, the cupboard was installed outside of the existing cupboard. This was not in line with best practice. Following the concerns raised during the inspection, managers raised an urgent request with the estates team to install a locked cupboard within a locked cupboard within the next 24 hours.

Medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within their use by date. Staff kept records of medicines fridge temperatures and ambient room temperature of their medicine rooms on the delivery suite, ante and postnatal wards.

We reviewed the medicine records for 11 women and found prescriptions were legible, named, dated, allergies and weight were clearly documented, and administration and route of administration were also clearly recorded. This was an improvement since our 2018 inspection, where we found women's weight and any allergies were not always documented.

Incidents

The service did not always manage safety incidents well. Staff recognised but did not report all incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, staff did not always have time to check emails to find updated incident information. When things went wrong, staff apologised and gave patients honest information and suitable support.

Although staff recognised incidents, they did not always have time to report them. The trust used an electronic reporting system which all grades of staff had access to. Staff we spoke with knew what incidents to report and how to report them. However, due to clinical pressures, they did not always have enough time to complete the incident form. Midwives told us that they did not always raise incidents if there were staffing issues and "assumed that senior staff would report them". This posed a risk of harm if all incidents had not been reported. Some staff also told us that they would report staffing incidents but had stopped doing so because they did not receive any feedback.

In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents in maternity which met the reporting criteria set by NHS England from December 2019 to December 2020.

We reviewed incidents reported on the National Reporting and Learning System by the trust from July to September 2020 which identified that term babies admitted to the neonatal unit were graded as no or low harm. This meant that incorrectly graded incidents may not be investigated and there was a risk that women were not informed of the significance of harm caused to them or their baby, or that appropriate action was taken to prevent further occurrences. We were not assured that incidents that were moderate, in line with definitions in Regulation 20 Duty of Candour guidance 2015, were always graded correctly according to the level of harm. We also saw that there were 11 incidents reported where safeguarding information was not transferred to all medical records. This meant that babies and young children may be at significant risk of harm if information was not shared appropriately. Following our inspection, divisional managers told us that all term admissions to the neonatal unit were reviewed by the weekly multidisciplinary team as part of the avoiding term admissions into neonatal units (ATAIN) programme. A nationally agreed proforma and a quarterly report was reviewed at maternity and neonatal governance meetings. Divisional managers said that the incidents may have been graded as 'no harm' as no omissions or avoidable harm in care were identified following review. Local incidents that were not deemed severe were monitored by the divisional governance team who also had oversight of all incidents.

Maternity

The trust had a duty of candour policy which staff could access through the trust's intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with women and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. However, where incidents were not graded correctly there was a risk woman may not receive the correct response, duty of candour and support from staff.

Learning from incidents was shared through email, newsletters and social media, however, not at meetings and handovers. Managers advised staff to check emails daily. However, staff told us that it was difficult to check emails daily due to staffing issues.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The service used monitoring results to improve safety. Staff used overarching national maternity indicators, as well as locally agreed standards, to provide oversight and assurance. Data submitted following the inspection stated the trust had stopped undertaking the point prevalence (safety thermometer) checklist in March 2020. The national requirement was halted in May 2020, within maternity services, as the data sample was small at the point of audit, the decision was taken to use the overarching national maternity safety indicators, supported by local safety and quality standards, to provide oversight and assurance. These indicators were scrutinised at monthly divisional quality meetings and provided assurance at the executive-led quality board and trust board quality committee. Immediate safety concerns would be highlighted through the daily safety huddles, incident management and professional escalation.

Is the service effective?

Good 

Our rating of effective stayed the same.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, some policies did not reflect all risk factors.

There was an effective system in place to ensure policies and clinical pathways reflected national guidance. The service had up to date policies in place that were reviewed every two to three years. We reviewed 10 policies and these were all in date and had dates for review. However, we saw that some policies did not mention all risk factors. For example, there

was no mention of high-risk women and the risk factors of managing women not in established labour. This meant that risks may not always be identified and acted upon appropriately. Staff were informed of updated guidelines via email, the weekly newsletter and staff noticeboards However, not all policies were multidisciplinary, this meant that some staff may not access all policies that would be beneficial to the care and treatment of women.

Mental health assessments were generally well completed. However, we reviewed 10 records and found in four episodes of care a mental health assessment had not been undertaken using the nationally recommended 'Whooley' questions. This meant that some women were at risk of not receiving appropriate care and referral if they were to develop a mental health condition during their pregnancy. Following our inspection, we asked managers whether the recently introduced electronic monitoring system would ensure that "Whooley questions" were routinely asked at each appointment to ensure all mental health issues were identified. Following our inspection, managers told us that the "Whooley questions" were a mandatory field in the new electronic record, therefore, they felt compliance would increase.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. When care and treatment was monitored, they used the findings to make improvements and achieved good outcomes for women.

Staff did not always monitor the effectiveness of care and treatment. When care and treatment was monitored, they used the findings to make improvements and mostly achieved good outcomes for women. The service maintained a maternity dashboard, which reported on birth activity, workforce, and obstetric and neonatal clinical outcomes. There were 41 performance measures detailed on the dashboard. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available. A traffic light system using red, amber, and green (RAG) ratings was used to flag most of the performance against agreed thresholds. A 'red flag' indicated areas that required action, to ensure safety and quality was maintained. Exceptions (red flags) reported on the maternity dashboard were reviewed monthly at the women and children's divisional governance meeting. Most red flags were in relation maternity staff sickness, maternity mandatory training for medical staff, and maternity skills and drills training for all grades of staff, anaesthetists, doctors, midwives and maternity support workers and midwife led care percentage at delivery.

The service had an audit programme in place for 2020/21. There were nine audits listed on the programme to meet national standards. Expected start and finish dates were identified. In addition, audits to provide local assurance and audits resulting from incidents were to be undertaken on an ad hoc basis. Weekly quality audits were undertaken by divisional matrons with results monitored by matrons and ward managers and reported at the divisional senior nurse meeting. Reports were presented at quality and safety meetings four weekly to highlight areas of concern and raise quality or safety issues. The reports concentrated on exceptions to allow dialogue and formulate actions. Quality audits undertaken included carbon monoxide monitoring, documentation of third trimester weight, weight recorded on medicine charts and routine enquiry into domestic abuse. Variations in performance and compliance had been identified in the quality audit report in all audits in all clinical areas from September 2019 to February 2020. Managers had previously addressed concerns with staff but planned to speak with staff again to improve compliance. Additional audits undertaken included safeguarding, safe sleeping audit and CTG recording.

Competent Staff

Training compliance had fallen during the COVID-19 pandemic but a plan was in place to improve this. However, the service generally made sure staff were competent for their roles.

Maternity

Preceptorship was provided for all newly qualified midwives to support staff in their first 12 months of registration and consolidate their training. Each new midwife had a buddy and a preceptor. Specific study days were also arranged. However, newly qualified midwives told us that their preceptorship study days had been cancelled. Managers told us that these cancellations were due to the COVID-19 pandemic, staffing and unit acuity. This meant that newly qualified staff were not able to access additional training to develop specific skills to meet their training requirements for example suturing, cannulation, intravenous therapy and one to one meetings to ensure a robust support programme. Following our inspection managers told us that all training events were now booked or available to be booked.

Professional midwifery advocates were in post to support the education and development of staff, provide clinical and restorative supervision and support individual midwives' personal development.

Midwives did not provide care to women on delivery suite with higher dependency needs, for example; arterial lines or central lines. Women with higher dependency needs were transferred to the high dependency unit. Directorate managers told us that if women were unable to be transferred to HDU, the anaesthetic team took responsibility for the higher dependency needs with support from the critical care outreach team. The women were under the care of the anaesthetist with daily review by the obstetrician therefore, no midwives were allocated on-shift to provide this care. The service had an up to date policy for managing the care of women with enhanced needs. Midwives continued to provide midwifery care to the mother and baby.

Compliance with appraisals for midwifery and medical staff in maternity was variable. As of 30 November 2020, appraisal compliance for all eligible medical staff was 100%. Overall compliance for nursing and midwifery registered staff was 73.1%. However, compliance for midwives was 67.12% against a target of 95%. Managers told us that appraisal compliance was reviewed at divisional board meetings monthly. During the COVID-19 pandemic response, personal development reviews (PDR) were delayed due to restrictions on face to face meetings. A data validation exercise was taking place and managers were encouraged to ensure that the electronic staff record was up to date and reflected any additional PDRs that had taken place since the emergence of the pandemic. Staff told us that they found the appraisal process useful to support their development.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.

Staff held regular multidisciplinary (MDT) meetings. We attended and observed the 8am MDT shift handover and found it was attended by all disciplines of the MDT. This included night medical and day staff, anaesthetist, the delivery suite co-ordinator and staff from the antenatal and postnatal wards as well as staff from the neonatal unit. However, there were two interruptions and some staff attended late. Additionally, there were daily local maternity service huddles to provide and receive support and overview from the local services.

Specialist midwives, such as the specialist diabetic midwife, were available to provide holistic care for women. However, staff told us specialist midwives were often deployed to work in other areas to provide cover. This meant that specialist midwives may not be able to undertake their specific roles or be readily available to provide specialist advice.

Staff of all disciplines told us that "teamwork was really good" and there was a cohesive team. Staff said that members of the MDT were comfortable to professionally challenge each other. Following our inspection, we received information from a student midwife who reported that "the midwives were supportive and enthusiastic and cared about each other and the women. It was inspiring to be involved in such a passionate team."

Maternity

Is the service well-led?

Requires Improvement 

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

Leadership

Although leaders mostly had the skills and abilities to run the service and understood the priorities and issues the service faced they did not always take timely action to address the concerns identified. They were visible in the service for women and staff.

Leaders were aware of the challenges the service faced and were visible to staff, however, timely action was not always taken to address the concerns identified within the service. The maternity service was managed through the trust's women's and children division. The senior leadership team comprised of a substantive head of midwifery, general manager and clinical director. Senior managers had recently recruited two new matrons to the service to provide leadership and expertise.

The leadership triumvirate met on a monthly basis to discuss operational issues and mitigating actions. Additionally, there was a daily local maternity service huddle with a neighbouring trust to discuss current operational issues, mitigating actions and support available. These meetings were commenced in March 2020. We attended the daily meeting. However, there was no agenda, no minutes taken, and no shared learning was observed. This meant that themes could not be clearly identified, nor actions taken audited to ensure any relevant changes in practice were made.

We met with members of the senior leadership team who demonstrated an awareness of the service's performance and the challenges they faced, including staffing issues and the concerns staff had with speaking with the freedom to speak up guardian. The senior leadership team identified the unfilled shift rate and discussed the maternity unit's staffing establishment. Although they described the immediate mitigating actions that were taken to cover vacant shifts there were not clear processes in place to provide evidence of how these shifts had been filled to meet patient acuity. We were told escalation processes were implemented but the frequency was not recorded. However, we were not assured that senior leaders always had full oversight of staffing, in order to deal with concerns raised by staff regarding low staffing levels and to ensure safe staffing levels.

Senior leaders had held a series of meetings with staff to address their concerns. Following the meetings an action plan was devised with actions taken to be reported to staff through a new divisional forum, and through improved communication channels. Additionally, leadership roles were to be reviewed, these included the review and development of the ward manager's and operational manager on call roles.

The head of midwifery reported to the chief nurse who reported maternity feedback to board. We noted that the head of midwifery had attended a board meeting in 2020 to provide direct information about the service.

New models of service delivery had been introduced including Continuity of Carer. Although there had been a gradual introduction of teams, staff told us that this had impacted on the numbers of staff within the rest of the department. A further team had been introduced during the pandemic. However, following staffing challenges the introduction of a further team rollout had been deferred.

Maternity

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.

The service had a vision for what it wanted to achieve developed with relevant stakeholders. The vision was focused on sustainability, the development of services, workforce, use of technology and was aligned to local plans within the wider health economy. It focused on providing safe, high quality, sustainable care for all. The vision of the division was "to see excellence rather than good". The vision was not publicly displayed throughout the maternity unit. Not all maternity staff were aware of the vision for the department. Staff told us that the vision for the department was not shared fully, they were not involved in the development of the strategy and vision. However, staff we spoke with were committed to providing safe care and improving the patient experience.

The staff model was evolving with new ways of delivering care being introduced. This included the redeploying staff due to COVID-19 and the roll out of the Continuity of Carer model. However, not all staff felt fully included in the planning and development of this change in practice. Staff told us that the introduction of the Continuity of Carer model was prioritised over midwives' welfare and preferences.

The service worked collaboratively with neighbouring trusts, clinical commissioning groups, other stakeholders, and service users to establish a local maternity system (LMS), in response to national recommendations.

Culture

Staff did not always feel respected, supported and valued by all managers. The service did not have an open culture where staff felt they could raise concerns without fear. However, staff were focused on the needs of women receiving care.

Staff did not always feel respected, supported and valued by all managers. Staff did however, feel that their colleagues were supportive and were all focused on providing good care to women. Most staff we spoke to told us that morale was low due to continuous short staffing. They told us that the impact of longstanding staffing issues had impacted on staff morale. All staff we met during our inspection were welcoming, friendly and helpful. However, all staff we spoke with raised concerns regarding midwifery safe staffing and felt that their views and comments regarding this were not considered. Staff reported continually escalating concerns to senior staff relating to staffing levels with no response.

Medical staff reported that they felt well supported, there was good learning from cases, a no blame culture, and colleagues were approachable.

The service did not always have an open culture where staff could raise concerns without fear. Staff told us that the FTSUG was a senior member of staff and staff felt that it was difficult to approach them to raise concerns. Senior managers provided staff with the contact details of other FTSUG link staff across the trust so that they could raise any concerns with them.

Maternity

All NHS trusts are required to nominate a FTSUG. The role of the FTSUG was to support staff who wished to speak up about a concern or issue and ensured that any issue raised was listened to and the feedback was provided to them on any actions or inactions because of them raising an issue. Between August and November 2020, the FTSUG service had received one enquiries in relation to the maternity service. Concerns raised were in relation to maternity staffing levels and lack of support**.**

Managers had provided psychological support for staff and had arranged a series of meetings to address concerns raised. An action plan was in place to address the issues. There were also open meetings that could be arranged with the chief executive if staff wanted this.

Governance

Whilst governance processes were in place leaders did not always operate these effectively throughout the service. Leaders liaised with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not all have regular opportunities to meet, discuss and learn from the performance of the service.

Whilst governance processes were in place, leaders did not always operate these effectively to continually improve the quality of its services and safeguard standards of care. The maternity governance structure replicated the triumvirate model across the trust. Monthly governance meetings were led by the associate divisional director and included a divisional governance report highlighting key issues including venous thromboembolism compliance, sepsis and absence of data, medication incidents, patient safety incidents, patient experience, training compliance and complaints. Meeting minutes for September, October and November 2020 identified that directorate and divisional reports for approval, the risk register and exception reports for National Institute for Health and Care Excellence were reviewed and feedback from other committees was discussed.

The head of midwifery was invited to present specific maternity related initiatives to quality governance committee. The divisional director reported into trust management executive. Risk and quality governance was reviewed on a monthly basis through quality groups and daily safety huddles which took place with the management team and matrons. Additionally, there were daily huddles with the neighbouring trust to provide support and oversight of acuity and staffing issues. However, there were no minutes for these meetings, nor was there an agenda.

The maternity service held joint monthly perinatal morbidity and mortality meetings with the children's service. December 2020 meeting minutes showed that maternity mortality cases from September 2018 to February 2019 were reviewed, lessons were learned, and changes made to practice.

During our inspection staff told us that they did not all have regular meetings. We requested meeting minutes and saw that there had been no antenatal clinic meetings since May 2020, a meeting of triage staff arranged for September 2020 was cancelled due to lack of attendance, community staff meetings were held in January, February and July 2020 some of these meetings were virtual meetings. However, labour ward meetings were held monthly. Team leader meetings were held monthly. We reviewed minutes for October, November and December 2020 and saw that quality and risk, infection prevention and control, patient experience and progress against the new IT system, continuity of carer and workforce were discussed. An extraordinary meeting had been held with community midwives in November 2020 to discuss concerns raised about the difficulties of covering on call rotas, the Continuity of Carer model of working and long

on call working hours. Following concerns raised by staff, managers had formulated an action plan to address their concerns. This included the re-instigation of meetings. We saw that there were monthly staff meetings held between October and December 2020. Meetings of maternity and neonatal safety champions were arranged monthly. There were no minutes from these meetings, therefore, progress and themes could not be measured or identified.

We found that whilst governance processes were in place, these were not always fully effective. There was a lack of oversight from the senior leadership and executive team. For example, managers were not auditing swab counts following vaginal deliveries. This meant that the senior leadership team could not assure themselves that there was no risk of a never event for retained swabs as they were not able to evidence the compliance level. Following our inspection, managers told us that the implementation of the electronic records system would allow for an audit schedule which would include swab audits to be conducted. We found that staff did not report incidents because of time constraints and an expectation that senior staff would report them. Processes had been revised relating to the governance of incident grading and appropriate review.

There was a lead non-executive director (NED) for maternity services. Managers told us that the NED had visited the maternity unit with the head of midwifery in 2019. There had been no further visits in 2020 due to the reduction of visiting associated with COVID-19. The service had a safety walkaround schedule. The NED had been involved in the virtual and physical safety walkaround schedule had continued and the maternity unit was scheduled for a virtual safety walkaround on 19 January 2021. However, this had been postponed due to the COVID-19 response.

Following an increase in complaints since July 2020 the governance team had initiated regular meetings to review complaints. Themes included delays in induction of labour and partners not being able to attend ultrasound scans. The complaints process had been revised to ensure that all draft responses were reviewed by the clinical director before the divisional management team.

The report submitted to the quality and safety meeting had been amended to include an 18-day deadline to encourage clinical leads to submit draft responses to the governance team in a timelier manner.

Management of risk, issues and performance

Although leaders and teams used systems to manage performance they did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. They did not have plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams used systems to manage some performance. They did not always identify and escalate some relevant risks and issues or identify actions to reduce their impact. The service had a governance lead, leading risk and quality governance with daily oversight on incidents and risk issues. Incidents were graded and reviewed, escalated where necessary and a review and timeline undertaken. All staff reviewing incidents were trained to do so. The governance team approved the final grading with quality assurance processes in place to provide consistency. A risk register was used to identify and manage risks to the service. The risk register contained 20 risks and included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, its possible impact and the review date were also included. Mandatory training and COVID 19 were documented risks on the divisional risk register, however lack of audit data was not included.

The service had an incident reporting programme. Mangers told us that changes had been made to how the system was working. Some categories had been reclassified in accordance with the trust guideline. The culture of reporting was

poor. All staff were able to report incidents. However, staff told us that they did not report all incidents, especially staffing incidents as they did not have time to do this and assumed senior staff would report. Managers were trying to increase the incident reporting culture and planned to provide training to raise awareness of incident categories. Weekly quality and safety review meetings were held to discuss incidents. We reviewed meeting minutes from September to December 2020 that demonstrated harm reviews were undertaken and identified actions required to be taken. Any potential harms in maternity were reviewed as part of the trust's incident review process. However, some consultants were reporting that they did not have time to undertake harm reviews. This meant that if risks were not adequately reported and reviewed, staff were not always contributing to the decision making which may have compromised the quality of care and led to financial pressures.

Although maternity staffing risks were mitigated by the movement of staff within the department the frequency of the implementation of the escalation policy was not clearly monitored. This meant that managers did not have clear oversight of the frequency of staff movement and the holistic risk of staff movement throughout the service was not captured nor was any potential financial impact.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. However, the dashboard was not displayed in clinical areas, this meant that staff and the public were not informed of the outcomes and risks of the maternity service.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Arrangements were in place to ensure confidentiality of maternity patient records was robust. We found the trolleys and filing cabinets where patient records were stored at the midwives' station and were lockable. Computer screens were closed when not attended. Staff had password access to electronic systems

An electronic specialist maternity records system was introduced in October 2020. However, this system was not introduced into the triage area therefore, paper records were maintained and scanned into the electronic record. Floor walkers were employed throughout the department to support the introduction of the system. Staff told us that this support had been helpful.

The service collected some reliable data and analysed it. However, not all audits were undertaken. For example, the division was outside the trust reporting system for sepsis, this had been escalated and work was ongoing with the associate divisional director for governance and the trust sepsis lead. In addition, the service was not auditing the Modified Early Obstetric Warning Score, local quality audits had been paused since March 2020 due to the trust COVID-19 response. This meant that managers could not be assured that risks to women and babies were identified and acted upon appropriately. Following our inspection managers told us that the maternity service was working on an updated quality template, specific to maternity services and the implementation of the electronic record system would allow for an audit schedule to be introduced.

Data or notifications were submitted to external organisations as required. The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical area KPIs. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. The parameters had been set in agreement with local and

national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK). This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

Leaders did not always engage with staff effectively. However, staff actively and openly engaged with women, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

Systems in place to engage with staff were not always effective. Staff told us team meetings did not take place regularly or they were unable to attend due to clinical pressures and short staffing. Staff told us they did not always feel they were kept informed and consulted about changes to the service provision, they did not always feel their views were listened, empathised with or acted upon.

Leaders engaged with women, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women. The service took account the views of women through the Maternity Voices Partnership. There were collaborative relationships with external partners and stakeholders to build a shared understanding of challenges within maternity and the needs of the local population, and delivery of services to meet those needs. The service was working collaboratively with service users, neighbouring trusts, and commissioners via the LMS, to ensure national recommendations for maternity care were implemented across the region.

Learning, continuous improvement and innovation

Although all staff were committed to providing good quality care timely action was not always taken to improve services.

Timely action was not always taken to address concerns previously identified within the service. This included concerns with staffing levels, concerns regarding the poor incident reporting culture amongst staff within the service, and low training compliance. We were not assured timely action was always taken to continuously improve and address the challenges and concerns identified within the service.

The service was involved in several research projects. These included both COVID-19 and non COVID-19 related research projects. COVID-19 projects included PAN-COVID research which aimed to evaluate the association of suspected COVID-19 and confirmed SARS-CoV-2 infection in women in pregnancy with miscarriage, fetal growth restriction and stillbirth, pre-term delivery and vertical transmission, and UK Obstetric Surveillance System a national system to study rare disorders of pregnancy. Non COVID-19 research included C-stitch, a study examining cervical sutures, big baby relating to reducing shoulder dystocia and cleft collective a cleft lip and palate research programme.

Areas for improvement

We told the trust that it must take action to bring services into line with two legal requirements. This action related to maternity services.

The trust must ensure that:

Maternity

- There is a process for monitoring if substantive staff working bank shifts worked additional hours to ensure no staff member is working excessive hours. Regulation 17(2)(d).
- The service assesses, monitors and mitigates the risks relating to the health, safety and welfare of service users and others who may be at risk; including ensuring the risk register reflects all risks. Regulation 17(2)(b).
- Staff recognised and report all incidents and near misses; and learning is shared effectively from incidents. Regulation 17(2)(b).
- Senior leaders have oversight of staffing, in order to deal with concerns. Regulation 17(2)(d).
- Their audit and governance systems remain effective. Regulation 17(2)(f).
- The service maintains accurate records relating to the planning and delivery of care and treatment. This includes governance arrangements, audits and meeting records. Regulation 17(2)(d).
- The service monitors the frequency that the escalation policy has been used. Regulation 17(2)(d).
- The service seeks and engages with staff for feedback to make any improvements without delay when they are identified. Regulation 17(2)(e).
- There are enough midwifery staff to deliver safe care and treatment. Regulation 18 (1).
- Staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. Regulation 18 (2) (a).
- Appraisal compliance for nursing and midwifery registered staff meets the trust target. Regulation 18(2)(a).

We told the trust that it should take action either because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that all women are referred to smoking cessation services. Regulation 12(2)(a).
- The service should ensure risk to women is identified appropriately and staff complete and update risk assessments for each woman or take action to remove or minimise risks Regulation 12(2)(a).
- The service should ensure that it monitors the effectiveness of care and treatment; and the findings are used to make improvements and achieve good outcomes for women. Including vaginal swab audits and carbon monoxide screening. Regulation 17(2)(f).
- The service should ensure there is an open culture for staff to raise concerns. Regulation 17(2)(e).
- The service should ensure all relevant safeguarding information is transferred to community staff on discharge from the department or safeguarding information transferred to the babies' record. Regulation 17(2)(c).
- The service should ensure information provided to the public is correct. For example, boards displaying planned and actual staffing figures. Regulation 17(2)(a).
- The service should ensure policies refer to all risk factors and that all staff can access relevant policies. For example, high-risk women and risk factors of managing women not in established labour. Regulation 17(2)(a).
- The service should consider baby abduction drills in maternity specific training to ensure all staff know what to do in such circumstances.
- The service should consider displaying safety information.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager and two specialist advisors. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

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
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RWP
Our reference	INS2-9977590611
Location name	Worcestershire Acute Hospitals NHS Trust

Regulated activity	Regulation
Maternity and midwifery services	**Regulation 17** **Good governance**
	How the regulation was not being met:
	There is a process for monitoring if substantive staff working bank shifts worked additional hours to ensure no staff member is working excessive hours. Regulation 17(2)(d). *• The service assesses, monitors and mitigates the risks relating to the health, safety and welfare of service users and others who may be at risk; including ensuring the risk register reflects all risks. Regulation 17(2)(b).* *• Staff recognised and report all incidents and near misses; and learning is shared effectively from incidents. Regulation 17(2)(b).* *• Senior leaders have oversight of staffing, in order to deal with concerns. Regulation 17(2)(d).* *• Their audit and governance systems remain effective. Regulation 17(2)(f).* *• The service maintains accurate records relating to the planning and delivery of care and treatment. This includes governance arrangements, audits and meeting records. Regulation 17(2)(d).* *• The service monitors the frequency that the escalation policy has been used. Regulation 17(2)(d).* *• The service seeks and engages with staff for feedback to make any improvements without delay when they are identified. Regulation 17(2)(e).*
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
There is a process for monitoring if substantive staff working bank shifts worked additional hours to ensure no staff member is working excessive hours. Regulation 17(2)(d). There is a Trust wide process in place for monitoring the EWTD for substantive hours and we can audit the hours through the ERostering system. There is also a contractual requirement for NHSP to monitor the Bank hrs. The Trust however needs to strengthen the conduit between both monitoring processes and will progress and evidence this.	

This is being led by the Director of people and Culture.

The service assesses monitors and mitigates the risks relating to the health, safety and welfare of service users and others who may be at risk; including ensuring the risk register reflects all risks. Regulation 17(2)(b).

The Women and Children's Division has a risk register that records generic risks that are relevant to all Directorates within the Division e.g. COVID and also the maternity specific risks. The following actions will be taken:

1. An enhanced process for managing risks at ward and departmental level is to be agreed.
2. A recent internal audit of risk management has identified areas, which require refinement and is currently being reviewed by the Corporate and Divisional Governance teams.
3. The risk register will be reviewed 'live' at the monthly Maternity Governance meetings, reviewed by the Divisional Management Team and then reported into the Trust Risk Management Group to provide assurance.

Staff recognised and report all incidents and near misses; and learning is shared effectively from incidents. Regulation 17(2)(b).

Prior to the inspection the divisional team had recognised via the weekly Quality and Safety Review Meeting (QRSM) that there was a lower than expected reporting culture. Trigger lists have been reviewed and relaunched in all areas of the Division and engagement events were held throughout December to ensure that staff understand the importance of reporting and how to report and accurately grade an incident.

The following actions will be taken:

1. Monthly ward engagement events which will be based on the programme completed in December 202..
2. Re-establish the maternity mandatory training days where a risk management session will be led by the Governance Team
3. Training events identified for team leaders, matrons and clinical leads to ensure their knowledge remains current and consistent to enable them to support the clinical teams in risk management.
4. Establish a feedback mechanism so that staff can engage in the further learning and recognise when action has been taken.
5. Reporting trends will continue to be reviewed at Quality and Safety Review Meeting and via Directorate and Divisional Governance meetings monthly

Senior leaders have oversight of staffing, in order to deal with concerns. Regulation 17(2)(d).

The following actions will be taken to ensure that midwifery safe staffing is reported from 'Ward to Board'

1. Re-establish ward to board reporting via Maternity Governance meetings *(this was suspended during wave 1 of the pandemic)*

2. Implement the new National antenatal and postnatal Birthrate acuity tool (2020).
3. Upgrade the current intrapartum acuity tool (*current version 2013)*
4. Director of Midwifery to complete a monthly midwifery safe staffing paper that will be reviewed at Board alongside the Nurse safe staffing paper, rather than a component part of the current Board staffing paper.
5. Director of Midwifery will continue to complete the required bi-annual safe staffing report and monitor staffing via the nationally agreed measures.
6. Staffing Key Performance indicators (KPIs) will be added to the Integrated Performance Report (IPR) that is presented to Board to support monitoring of trends and flag any safety issues.
7. Safety Champion walkabouts will continue and a robust recording mechanism will be agreed to ensure that concerns, themes and actions are captured.
8. The process for managing daily safe staffing will be described in detail in the revised safe staffing and escalation policy.

Their audit and governance systems remain effective. Regulation 17(2)(f).

To ensure that the required audits are undertaken the Directorate team will:

1. Review the audit plan to ensure that it captures all of the recommended audits to demonstrate that a safe and improving service is provided
2. Re-establish the ward quality audits *(this was suspended during wave 1 of the pandemic)* rather than the Safety huddle tool which was implemented during COVID.
3. Identify funding to ensure that there is adequate support within the Governance Team to monitor compliance with the agreed audit plan.
4. Report all audits via monthly Maternity Governance Meeting.
5. Consider development of a separate forum to present audits and guidelines.

The service maintains accurate records relating to the planning and delivery of care and treatment. This includes governance arrangements, audits and meeting records. Regulation 17(2)(d).

Prior to the inspection in December 2020 all maternity staff attended a one day mandatory training event prior to the implementation of the electronic maternity information system (Badgernet). Further bespoke training has been made available for community staff who required additional support. The training supported the team not only to be able to navigate the system but provided an opportunity for staff to be reminded about the completion of accurate and complete documentation.

To ensure that records are accurate and complete the following actions will be taken:

1. Quarterly documentation audits will be completed by the Digital Midwife and reported at the Maternity Governance meeting
2. The quality audits will be re-established and reports provided monthly at QRSM.

The service monitors the frequency that the escalation policy has been used. Regulation 17(2)(d).

Currently the maternity inpatient service is expected to record escalation via Datix and the community midwifery team complete a spreadsheet that records out of hours activity. It is recognised that this is not robust. The Directorate will take the following actions:

1. Review the current escalation policy to ensure that provides clear and comprehensive guidance to all staff groups on when to escalate and how this should be reported.
2. Develop a digital tool to record all events when escalation has taken place, actions taken and the rationale for the planned action. The tool will also record the impact of all decisions made on all other clinical areas and record which leader made those decisions.
3. The information recorded within the escalation tool will be reported in the monthly safe staffing report to ensure that both the Division and Board have oversight of the frequency of the use of the escalation policy.

The service seeks and engages with staff for feedback to make any improvements without delay when they are identified. Regulation 17(2)(e).

To ensure that staff are able and encouraged to provide feedback to make service improvements the following actions will be taken:

1. Re-establishment of monthly ward and team meetings (Post COVID escalation) with recorded meeting notes and actions.
2. Continue with the established divisional briefings
3. Continue with Directorate business and governance meetings, which are attended by leaders within the Women's Directorate
4. Commence directorate led briefings
5. Commence Director of Midwifery Q&A sessions
6. Develop Professional Midwifery Advocate (PMA) offer within maternity services; consider development of a Lead PMA role.
7. Work with the Organisational Development team to improve team culture
8. Develop an action plan to respond to the findings of the staff survey
9. Complete the 2nd NHSI safety culture survey and arrange for debriefs to facilitate change.

Who is responsible for the action?	Angus Thomson, Divisional Director Justine Jeffery, Director of Midwifery Becky Williams, Divisional Director of Operations

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

All actions will be monitored as part of the Divisional Improvement action plan via the Divisional Governance meeting. The embedded action plan will confirm responsibility and

timescales for completion. The Quality Hub will collect the available evidence to ensure an improvement has been made. The continued and sustained improvement will be monitored via Divisional Meetings and at our monthly regulated Activity Improvement Tool (RAIT) meetings with the Chief Nursing Officer (CNO). Attached	
Who is responsible?	Angus Thomson, Divisional Director Justine Jeffery, Director of Midwifery Becky Williams, Divisional Director of Operations

What resources (if any) are needed to implement the change(s) and are these resources available?	
• Procure acuity tools • Employ an audit lead • IT support to develop App for escalation	
Date actions will be completed:	Please refer to action plan for timescales

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is a potential for reduced confidence in the safety and quality of the maternity service if we receive further adverse publicity or receive further enforcement from CQC. The action plan will be monitored as outlined to ensure delivery.

Completed by: (please print name(s) in full)	Angus Thomson Becky Williams Justine Jeffery
Position(s):	Divisional Director Divisional Director of Operations Director of Midwifery
Date:	1st March 2021

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 Staffing
	How the regulation was not being met:
	There are enough midwifery staff to deliver safe care and treatment. Regulation 18 (1). *• Staff complete mandatory, safeguarding and any additional role specific training in line with the trust target.* *Regulation 18 (2) (a).* *• Appraisal compliance for nursing and midwifery registered staff meets the trust target. Regulation 18(2)(a).*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

There are enough midwifery staff to deliver safe care and treatment. Regulation 18 (1).

Throughout Q3, 2020 two recruitment events were undertaken and 11 WTE midwives were recruited. On 26th February, 2021 a further 6.8 WTE midwives were offered posts for all community staff posts. In December 2020 the Trust Board agreed additional funding for 10 WTE posts to support the directorate to manage the COVID impact and a rolling advert is currently in progress to ensure that all vacancies and all of the additional posts are filled.

To ensure this position is sustained the directorate will:

1. Complete the planned review of the “Birthrate Plus” tool to inform workforce requirements for 2021-2024.
2. Procure acuity tools to support monitoring of required workforce.
3. Work with the finance team to ensure that the information held on staff in post is correct.
4. Continue to work with ERoster to ensure there are effective rosters produced.
5. Manage sickness in accordance with the trust Absence Management Policy.
6. Review the current Safe Staffing Guidance and ensure that the daily process for managing staffing is described in the guidance and audit documentation of actions.
7. Review preceptorship programme to ensure that all new starters are supported and clinical services are staffed safely.
8. Continue to work with Health Education England (HEE) to develop Band 3 Maternity Support Workers (MSW) in all non-intrapartum maternity settings.

Staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. Regulation 18 (2) (a).

The Trust mandatory training compliance rate has been agreed at 90% for 2021. Compliance rates in maternity, by specific courses, are variable. The directorate will ensure that:

1. All staff are given the appropriate time to complete all mandatory and safeguarding training. This will be monitored via directorate and divisional meetings and actions taken

to address poor performance.

2. No additional study leave will be granted if compliance is less than 90%
3. Mandatory Training and other training compliance is also discussed and reviewed on an individual basis through Personal Development Review (PDR) meetings with each member of staff.
4. The action plan shared with CQC inspectors in December 2020 is being monitored by the Divisional Management Team to ensure that all role specific multi-professional training is completed by July 2021.
5. Continue Divisional Briefings with the teams to update them on progress.

Appraisal compliance for nursing and midwifery registered staff meets the trust target. Regulation 18(2)(a).

The following actions will be taken to ensure that PDR compliance is met and then monitored:

1. The directorate will ensure that all staff with an outstanding PDR will be prioritised for completion by the end of July 2021.
2. All other PDRs will be planned and a date given to each individual to reduce the risk of PDR expiry and maintain a sustained model of improvement
3. The PDR rate will be monitored via Directorate and divisional meetings and actions taken to address poor performance.

Who is responsible for the action?	Angus Thomson, Divisional Director Justine Jeffery, Director of Midwifery Becky Williams, Divisional Director of Operations

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

All actions will be monitored as part of the Divisional Improvement action plan via the Divisional Governance meeting. The embedded action plan will confirm responsibility and timescales for completion. The Quality Hub will collect the available evidence to ensure an improvement has been made.

The continued and sustained improvement will be monitored via Divisional Meetings and at our monthly RAIT meetings with the CNO.

Who is responsible?	Angus Thomson, Divisional Director Justine Jeffery, Director of Midwifery Becky Williams, Divisional Director of Operations

What resources (if any) are needed to implement the change(s) and are these resources available?

- Procure acuity tools
- Procure Birthrate Workforce Audit
- Identify funding for Lead PMA

Date actions will be completed:	Please refer to action plan for timescales

How will people who use the service(s) be affected by you not meeting this regulation until this date?
A reduce and/or untrained workforce could lead to a poor quality service which may increase the risk of avoidable harm.

Completed by: (please print name(s) in full)	Angus Thomson Justine Jeffery Becky Williams
Position(s):	Divisional Director Director of Midwifery Divisional Director of Operations
Date:	1st March 2021

Worcestershire Acute Hospitals NHS Trust

Women & Children Division
Maternity Services Open Meetings & CQC Action Plan

RAG Rating Key:

Completion Status	
	Overdue
	Delay to completion expected
	On track for delivery date
	Complete

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB/ CQC	**Repeatedly reduced staffing numbers available on shift across all areas of service.**	Recruit to all vacant posts including those on community on a rolling basis	Matrons	Next recruitment by end Nov 20	Job adverts out in September 2020 – February 2021 , PS and JD reviewed for PN ward manager post ATR to be completed by 10.10.20 31.1.2021 11 WTE posts offered 26. 2.21 6.8 WTE posts offered to fill all community service vacancies	
SB		Ensure recruitment to maternity leave before 20 weeks	Matrons	From Dec 2020 Ongoing	See above	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB		Do a detailed review of sickness by area to identify any additional actions	HR Business Partner	End Jan 2021		
SB	**Staffing levels**	Weekly HR meeting with ward managers /matrons	HR advisory team / ward managers & matrons	Weekly from Dec 2020		
SB		Detailed turnover report from workforce team to be requested	HR Business Partner	Monthly from Jan 2021		
SB		Develop and implement a local exit interview process	Matron MH	15 Dec 2020	Complete	
SB		Ensure secretaries have correct letter template for leavers	Matron - MH	20 Nov 2020	Complete	
SB		Triangulate themes from turnover data and exit interviews	HR Business Partner / HR advisory team	From End Jan 2021 Review monthly	Turnover rates reviewed at monthly directorate meetings.	
SB/ CQC		Matron oversight of the creation and publication of e-roster	Matrons	From Dec 2020 and then monthly	31.1.21 Further work undertaken with Trust Allocate Lead to improve ability of managers completing the rota	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB	**Staffing levels cont…**	Clarify process for NHSP shifts – ensure that shifts are being put out in timely way	Matron KH	End Nov	Complete. Conversation with roster admin aware that NHSP shifts are to go out as soon as roster approved	
SB		Ensure rotas are published in a timely way and with at least 8 weeks' notice	Matrons	From Dec 2020 and then monthly	20.2.21 Weekly confirm and challenge meetings chaired by DoNM commenced to monitor progress with action	
SB		Review all flexible working arrangements	Matrons/ward manager	End Mar 2021	20.2.21 Ongoing review vis C& C meetings	
SB/ CQC		Arrange Birth Rate Plus meeting	Director of Gynae Nursing & Midwifery (DoNM)	End Jan 2021		
SB/ CQC		Birthrate plus audit to be completed in 2021	DoNM / DDOps	End May 2021	Meeting confirmed 26.2.21 with BR + to scope the requirement	
SB/ CQC	**Escalation and oncall**	Set up task and finish group to strengthen escalation policy around required safe staffing linked to activity and acuity	DoNM / Matrons	End Mar 2021	1.2.21 Minimal progress noted to date 20.2.21 Matron identified to lead on development –first draft expected by end of March	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB	**Escalation and oncall cont…**	To have discussions with each community team about countywide rota and develop plan	Matron - MS	End Dec 2020	4/5 community on call rota agreed – feedback heard at Community Forum and risk added to the risk register 25.2.21 WEB 4633	
SB/ CQC		Review alternative escalation options when staffing required for inpatient services	DoNM	End Jan 2021	Staff identified a small number of Trusts and it has been established that this is provided on a voluntary basis - no further progress agreed with this model	
SB		Clarify how the on-call payment and time off in lieu works, and communicate this to community teams	Matron – MS	End Dec 2020	Shared via local community team meetings	
SB	**Increased acuity, activity & poor flow**	Communicate outcome of findings and actions of induction of labour task and finish group on induction (regular updates on progress)	Consultant Midwife / Consultant lead (Mr Suraweera)	Monthly update starting Dec 2020	Audit shared but ongoing TF group actions/delay audit commenced Jan 2021	
SB		Identify lead each day to ensure theatre lists starts on time and progress well	Anaesthetic lead / Theatre Band 7/Matron - KH	End Dec 2020	Core elective team identified by Matron to trial in Q4 2021	
SB		Review booking of maternity theatre lists	Anaesthetic lead / Theatre Band 7/Matron - KH	End March 2021	Due date extended due to unexpected leave of Matron	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB	**Breaks on a long shift**	Identify additional roles to help support breaks through escalation to 223	Matrons	End Nov 2020	Complete – ward managers and other non-clinical midwives to be called upon during times of escalation.	
SB		Create staffing email inbox that all staffing queries and requests go to for processing	Matrons	End Dec 2020	Not required - agreed new process now 2nd Matron in post	
SB		Working with 223 / ward managers / matrons to review how breaks are covered	Matrons	Covered by escalation actions		
SB		Communication via line managers / FB page of the location of the quiet room in maternity	Matrons /ward managers	End Nov 2020	Completed	
SB		Identify any other areas in the Trust who have not moved to 1 hour break in a long shift	Divisional Director	End Nov 2020	Completed - ED and dialysis unit	
SB	**Continuity of Carer**	Slow roll out of continuity of carer teams	Consultant midwife / DNM	End Nov 2020	Complete – delay next team – timescale TBC	
SB		Strengthen the SOP (Standard Operating Procedure) for CoC to reduce variation between teams	Consultant Midwife	End Nov 2020	Completed	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB	**Continuity of Carer cont…**	Circulate SOP for comment	Consultant Midwife	Mid Dec 2020	Out for comments in Dec 2020 – recirculated for feedback as no comments received from staff groups.	
SB		Incorporate comments and disseminate CoC SOP	Consultant Midwife	End Jan 2021	Delayed as minimal comments received from staff on first circulation in December 2020. To ensure all staff have had the opportunity to comment recirculated to encourage comments causing delay to meet initial completion deadline.	
SB		Meet with labour ward co-ordinators to ensure there is a clear understanding of CoC SOP	Consultant Midwife/ Matrons	End Feb 2021	Once agreed at Maternity Governance will be shared again with team for clarification – delayed due to minimum comments received following initial circulation in December 2020.	
SB		Team wide engagement and information about CoC to aid its integration in the wider service.	Consultant Midwife /Matrons	End Jan 2021	Study day arranged 1st March 2021	
SB	**Communication**	Share team structure, ensure team members understand the team leader they report to	Divisional team	End Jan 2021	Delay due to retirement of ward manager Shared via email and in effective handover w/c 1.3.21	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB		Revamp effective handover	Matrons / ward managers / communications	End Mar 2021	Matron oversight re-introduced.	
SB/ CQC		Arrange virtual Divisional team brief open to whole Division	Divisional team	End Jan 2021	Complete Maternity specific briefing in December 2020 Division wide monthly briefing from Feb 2021	
SB	**Communication cont…**	Share information on freedom to speak up champions and how to access	FTSU lead	End Nov 2020	Complete	
SB/ CQC		Reinstate team meetings	Ward/team/department managers	Start Jan 2021		
SB/ CQC		Ensure ward to board reports are escalated through Directorate Governance to Divisional Governance meetings	Matrons / Clinical Director	Monthly starting Dec 2020 – June 2021	To monitor for 6 months	
SB/ CQC		Resume Safety champions walkabout and feedback to Directorate / Divisional teams	Safety champions	Monthly starting Dec 2020 March 2021	Recommenced in August 2020 Process for documenting walkabouts to be reviewed.	
SB		Raise awareness of availability of Meet the chief sessions	Matrons	Monthly from Dec 2020	Reminded staff at Divisional feedback session	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB/ CQC	**Reduced midwifery leadership**	Recruitment to all matrons posts	DoNM	Jan 2021	Intrapartum matron has started. Community and continuity postholder to start in Jan 2020	
SB		Review and develop ward managers role	Matrons / DoNM	End Mar 2021	Jan 2021 JD reviewed – advert out for postnatal ward manager	
SB/ CQC	**Reduced midwifery leadership cont…**	Review role of operational manager on call	Matrons / DoNM	End Mar 2021	Will be described in escalation policy	
SB/ CQC		Review provision of 223 role	Matrons / DoNM	End Mar 2021	Will be described in escalation policy	
SB	**Staff support and wellbeing**	Ensure visible leadership available to support the team via regular walkabouts and daily ward manager / matron presence	Matrons / Ward Managers	Start immediately	In place	
SB/ CQC		Communicate Trust wellbeing offer to colleagues Bespoke package to be developed for midwives	HR/Divisional team	End Oct 2020 April 2021	Complete. Shared with staff via email and facebook page TF group developed –led by Matron with support from HR	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB/ CQC		Strengthen the PMA team and consider the development of lead PMA	DoNM	End April 2021		
SB/ CQC		Develop staff survey action plan with teams throughout Division	HR BP / Directorate teams / Divisional teams / All staff	End Mar 2021		
SB	**Equipment**	Ensure Redditch assets are all transferred to Siemens	DDOps	March 2021	Completed before March 2021	
SB	**Equipment cont…**	Review of equipment requests that are outstanding	Matrons / DDOPs	End Oct 2020	Complete. Delays identified and progressed	
SB		Assessment of available equipment against what is required for each department and new equipment to be ordered where required	Ward managers	End Jan 2021	Jan 2021 P/O raised for sonic aids, pumps and observation equipment.	
SB	**Team working**	Discussion with gynae matron to develop an agreement for enhanced support that can be offered by gynae team	DDNM	End Nov 2020	Complete. Gynae team will support maternity when in escalation. This will be described in the escalation policy.	
SB		Introduction of evening huddle with theatre team to understand workload	Matron for theatres	End Nov 2020	Complete. Morning and evening	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
SB		Explore additional roles that may provide support	DDNM	End Nov 2020	Complete Engaged in HEE MSW development programme.	
SB		Complete scoping work around MSWs; funding received from HEE to complete this work	DDNM	End Mar 2021	28.2.21 As above –work continues and will meet milestones.	
SB		Review ward clerk numbers	Matrons	End Jan 2021	Administrative review to be undertaken by Divisional Management Team.	
SB/ CQC	**Team working cont…**	Cross county community meetings to be reintroduced by community matron	Community Matron	End Jan 2021	First Community Forum held on 11.02.21	
SB		Recruit more 4ward advocates in Maternity	HR Business Partner	End Jan 2021	MH met with 4ward advocate 27.11.20, active recruitment campaign to be commenced, Advocate training every week, two potential advocates already identified	
SB		Arrange for CoC midwives to talk to other teams to talk about their team	Consultant	End Jan 2021	Completed- led by Matron and CM.	
SB	**Links with primary care and community services**	Liaison with health visiting leads re: provision of face to face appointments	DoNM	End Nov 2021	Complete – ongoing work planned with HV team to review visiting schedule in the antenatal and postnatal period.	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		Some GPs not allowing Midwives back into surgeries. Attend meeting with GP Clinical Directors	DoNM	Oct 2020	Complete – GPs unable to let midwives back in due to space constraints. Alternative space sourced.	
	CQC Recommendations	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG
CQC	**There is a process for monitoring if substantive staff working bank shifts worked additional hours to ensure no staff member is working excessive hours. Regulation 17(2)(d).**	The Trust will develop a process for monitoring hours worked to ensure that those who have not declared their wish to not adhere to the EWTD work within the directive.	Director of HR	June 2021		
CQC	The service assesses monitors and mitigates the risks relating to the health, safety and welfare of service users and others who may be at risk; including ensuring the risk register reflects all risks. Regulation	1. The process for recording and reviewing risks is currently under review by the Corporate Governance Team and an agreed process for managing risks and ward and departmental level is to be agreed.	Corporate Governance Lead	April 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
	17(2)(b).					
		2. The Division has an agreed process for monitoring and updating risks.	Associate Director for Women & Children's Division/Divisional Governance Lead	May 2021		
		3. The risk register will be reviewed 'live' at the monthly Maternity Governance meetings, reviewed by the Divisional Management Team and then reported into the Trust Risk Management Group to provide assurance.	Associate Director for Women & Children's Division/Divisional Governance Lead	March 2021		
CQC	Staff recognised and report all incidents and near misses; and learning is shared effectively from incidents. Regulation 17(2)(b	1. Monthly ward engagement events which will be based on the programme completed in December.	Associate Director for Women & Children's Division/Divisional Governance Lead	March 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		2. Re-establish the maternity mandatory training days where a risk management session will be led by the Governance	Associate Director for Women & Children's Division/Divisional Governance Lead	March 2021		
		3. Training events identified for team leaders, matrons and clinical leads to ensure their knowledge remains current and consistent to enable them to support the clinical teams in risk management.	Associate Director for Women & Children's Division/Divisional Governance Lead	June 2021		
		4 Establish a feedback mechanism so that staff can engage in the further learning and recognise when action has been taken.	Associate Director for Women & Children's Division/Divisional Governance Lead	April 2021		
		4 Reporting trends will continue to be reviewed at QRSM; and via Directorate and Divisional Governance meetings monthly	DMT	Ongoing		
CQC	Senior leaders have oversight of staffing, in order to deal with concerns. Regulation 17(2)(d).	1. Re-establish ward to board reporting via Maternity Governance meetings *(this was suspended during wave 1 of the pandemic)*	Matrons	February 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		2. Implement the new antenatal and postnatal Birthrate acuity tool.	DoM	March 2021		
		3. Upgrade the current intrapartum acuity tool (current version 2013)	DoM	March 2021		
		4. Director of Midwifery to complete a monthly midwifery safe staffing paper that will be reviewed at Board alongside the nurse safe staffing paper	DoM	February 2021		
		5. Director of Midwifery will continue to complete the required bi-annual safe staffing report and monitor staffing via the nationally agreed measures	DoM	February 2021		
		6. Staffing Key Performance indicators (KPIs) will be added to the Integrated Performance Report (IPR) that is presented to Board to support monitoring of trends and flag any safety	DoM?Informatics Team	March 2021	f/u meeting arranged for 11.321	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		issues.				
		7. Safety Champion walkabouts will continue and a robust recording mechanism will be agreed to ensure that concerns, themes and actions are captured.	CNO/DoM/Safety Champions	Ongoing	Recommenced in August 2021	
		8. The process for managing daily safe staffing will be described in detail in the revised safe staffing and escalation policy	DoM	March 2021		
CQC	Their audit and governance systems remain effective. Regulation 17(2)(f)	1. Review the audit plan to ensure that it captures all of the recommended audits to demonstrate that a safe and improving service is provided	CD/Clinical Leads	March 2021		
		2. Re-establish the ward quality audits *(this was suspended during wave 1 of the pandemic*	DoM	March 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		3. Identify funding to ensure that there is adequate support within the Governance Team to monitor compliance with the agreed audit plan.	DoPs	April 2021		
		4. Report all audits via monthly Maternity Governance Meeting.	Associate Director for Women & Children's Division/Divisional Governance Lead	April 2021		
		5. Consider development of a separate forum to present audits and guidelines.	Associate Director for Women & Children's Division/Divisional Governance Lead	April 2021		
CQC	The service maintains accurate records relating to the planning and delivery of care and treatment. This includes governance arrangements, audits and meeting records. Regulation 17(2)(d).	1. Quarterly documentation audits will be completed by the Digital Midwife and reported at the Maternity Governance meeting	Associate Director for Women & Children's Division/Divisional Governance Lead	May 2021		
		2. The quality audits will be re-established and reports provided monthly at QRSM.	DoM	March 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
CQC	The service monitors the frequency that the escalation policy has been used. Regulation 17(2)(d).	1. Review the current escalation policy to ensure that provides clear and comprehensive guidance to all staff groups on when to escalate and how this should be reported.	DoM	March 2021		
		2. Develop a digital tool to record all events when escalation has taken place, actions taken and the rationale for the planned action. The tool will also record the impact of all decisions made on all other clinical areas and record which leader made those decisions.	Dom.CNO/Informatics/IT/ Quality Hub	June 2021	Monitoring of robust completion of the acuity tools will be maintained whilst tool in development.	
		3. The information recorded within the escalation tool will be reported in the monthly safe staffing report to ensure that both the Division and Board have oversight of the frequency of the use of the escalation policy.	DoM	June 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
CQC	The service seeks and engages with staff for feedback to make any improvements without delay when they are identified. Regulation 17(2)(e).	1. Re-establishment of monthly ward and team meetings with recorded meeting notes and actions.	Matrons	January 2021		
		2. Continue with the established divisional briefings	Divisional Director	Ongoing		
		3. Continue with Directorate business and governance meetings, which are attended by leaders within the Women's Directorate	DoM/CD/DM	Ongoing		
		4. Commence directorate led briefings	CD/DM/DoM	April 2021		
		5. Commence Director of Midwifery Q&A sessions	DoM	March 2021		
		6. Develop Professional Midwifery Advocate (PMA) offer within maternity services; consider development of a Lead PMA	DoM/DoPs	April 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		role.				
		7. Work with the Organisational Development team to improve team culture	DoM/DoPs	December 2020	Scoping work completed further sessions arranged.	
		8. Develop an action plan to respond to the findings of the staff survey	HR Business partner	April 2021		
		9. Complete the 2nd NHSI safety culture survey and arrange for debriefs to facilitate change	DoM/CD/DM	September 2021		
CQC	There are enough midwifery staff to deliver safe care and treatment. Regulation 18 (1).	1. Complete Birthrate Plus to inform workforce requirements for 2021-2024.	DoM/DoPs	May 2021	Scoping meeting arranged 26.2.21	
		2. Procure acuity tools to support monitoring of required workforce.	DoM/DoPs	May 2021	Scoping meeting arranged 8.2.21	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		3. Work with the finance team to ensure that the information held on staff in post is correct	DoM/DoPs/DM	Feb 2021		
		4. Continue to work with ERoster to ensure there are effective rosters produced	DoM/Allocate Lead	Feb 2021	Meetings completed with rota creator and ward managers	
		5. Manage sickness in accordance with the trust Absence Management Policy.	HR Lead/WM/Matrons	March 2021	Ongoing support provided from HR. Confirm and challenge meetings arranged for next 6 months	
		6. Review the current Safe Staffing Guidance and ensure that the daily process for managing staffing is described in the guidance.	Matrons/DoM	March 2021	Matron Lead identified.	
		7 Review preceptorship programme to ensure that all new starters are supported and clinical services are staffed safely.	Consultant MW/Preceptorship Lead	April 2021	Changes to programme implemented in February 2021 –further work to be agreed	

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		8 Continue to work with Health Education England (HEE) to develop Band 3 Maternity Support Workers (MSW) in all non-intrapartum maternity settings.	Lead Midwife/DoM	March 2021	Expected milestones met to date. Final report expected end of March	
CQC	Staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. Regulation 18 (2) (a).	1. All staff are given the appropriate time to complete all mandatory and safeguarding training. This will be monitored via directorate and divisional meetings and actions taken to address poor performance.	Ward managers/Matrons/ CD/DM	March 2021		
		2. No additional study leave will be granted if compliance is less than 90%	Ward managers/Matrons/ CD	March 2021		
		3. Mandatory Training and other training compliance is also discussed and reviewed on an individual basis through Personal Development Review (PDR) meetings with each member of staff.	Ward managers/Matrons/ CD	March 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		4. The action plan shared with CQC inspectors in December 2020 is being monitored by the Divisional Management Team to ensure that all role specific multi-professional training is completed by July 2021.	PDM/ Associate Director for Women & Children's Division/Divisional Governance Lead	July 2021		
		5. Continue Divisional Briefings with the teams to update them on progress.	DMT	Ongoing		
CQC	Appraisal compliance for nursing and midwifery registered staff meets the trust target. Regulation 18(2)(a).	1. The directorate will ensure that all staff with an outstanding PDR will be prioritised for completion by the end of July 2021.	Ward managers/Matrons/ CD	March 2021		

No. (Ref)	Key Challenge	Action Point	Owner	Due Date (if applicable)	Comments/Update	RAG rating
		2. All other PDRs will be planned and a date given to each individual to reduce the risk of PDR expiry and maintain a sustained model of improvement	Ward managers/Matrons/ CD	March 2021		
		3. The PDR rate will be monitored via Directorate and divisional meetings and actions taken to address poor performance	CD/DoM/DM	March 2021	Directorate meetings to restart post COVID 2nd wave	

NHS
Worcestershire Acute Hospitals NHS Trust

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Going Concern Paper 2020/21

For approval:	X	For discussion:		For assurance:		To note:	

Accountable Director	R D Toole, Chief Finance Officer		
Presented by	Robert D Toole, Chief Finance Officer Katie Osmond, Deputy Director of Finance	**Author /s**	Katie Osmond, Deputy Director of Finance Lynne Walden, Head of Financial Planning and Financial Services. Marie Hall, Deputy Head of Financial Services

Alignment to the Trust's strategic objectives (x)							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	✓	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	17 February 2021	Noted
FPC	24 February 2021	Endorsed

Recommendations	The Finance and Performance Committee recommend the Trust Board to endorse the Chief Finance Officer's recommendation that the Trust is a going concern. This in readiness for further approval by the Trust Board despite the significant cash requirement within the 2021/22 draft financial plan.

Executive Summary	The concept of "going concern" is one of the fundamental principles underpinning the accounting regime used in preparation of our financial statements. Essentially it means the Directors believe we have the resources in place to remain viable for the foreseeable future. Directors should consider the specific events, conditions and factors that individually or collectively, might cast significant doubt on the going concern assumption. We must comply in the preparation of our annual accounts to the NHS Group Accounting Manual (GAM). The going concern section has been included in Appendix 1 for reference. We face a range of risks, and continue to be impacted financially and operationally by the COVID-19 pandemic. We were finalising the 2020/21 financial plan and contract negotiations when the COVID-19 pandemic resulted in the national planning process

being paused and an interim financial architecture introduced.

At the point the planning process was paused, we had a planned deficit for 2020/21 of £(78.9)m. We requested and accessed £7.7m of revenue cash support in April 2020, prior to confirmation of the COVID-19 financial architecture, but have not requested any further revenue support due to high cash balances resulting from the timing of receipts in year.

Through the interim architecture, non-recurrent top up funding was received in the first half of the year to offset costs to achieve break even. Following publication of Phase 3 guidance and changes in top up payments for the second half of the year, the Board agreed a forecast deficit of £(7.2)m. This was revised at month 9 following a slower than anticipated rise in activity (and thus cost), to an in-year deficit for 2020/21 of £(2.5)m.

Unless the forecast outturn improves to achieve break-even over the final quarter, 2020/21 will be the 8th consecutive year in which the Trust has not achieved its in year breakeven duty. A continued breach will result in the requirement for a further referral by the external auditor to the Secretary of State. We have been in a cumulative deficit for over 10 years although historic revenue support loans were converted to PDC during 2020/21, strengthening the balance sheet.

In the NHSE&I breakeven duty guidance April 2018 an auditor's responsibilities are defined as follows:

"The external auditors of NHS trusts have responsibilities under section 30 of the Local Audit and Accountability Act 2014 to report on unlawful matters by issuing a referral to the Secretary of State. External auditors are also required to follow the Comptroller and Auditor General's Code of Audit Practice, issued by the National Audit Office (NAO), and have regard to the accompanying auditor guidance notes (AGNs). These are available on the NAO website and AGN07 explains the auditor's responsibilities for reporting. Auditors generally consider a trust's failure to meet the breakeven duty requirements to be an unlawful matter requiring a referral to the Secretary of State."

The primary risk to us remaining a going concern is the underlying financial deficit (once non recurrent top up funding from 2020/21 is removed) and a resultant shortfall in cash to discharge our liabilities.

During January 2021, it was confirmed that the interim arrangements would be rolled over to quarter 1 in 2021/22, with organisations expected to progress planning for quarters 2 – 4 over the coming months. Although planning guidance is not yet available, through regional teams, systems have been asked to review their underlying exit run rates from 2020/21. This exercise has demonstrated that once non recurrent 2020/21 top up funding is removed, and other non-recurrent / full year

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	effect adjustments made the Trust would remain in a material deficit positon. There will be a requirement for cash to support any deficit position in the event that the final financial plan remains a material deficit. Access to cash support remains through monthly requests to the Department of Health and Social Care in line with the standard NHSE&I process. To date all requests that have been made in line with national policy have been approved. As such, we have no reason to assume that this support will cease to be made available to us, or that the terms on which cash is provided would change. On the balance of assessment of the various risks, opportunities and uncertainties, the Chief Finance Officer recommends that the Trust considers itself to be a going concern in line with published guidance. On this basis, the Trust Management Executive is requested to consider and endorse this recommendation in readiness for further endorsement at the Finance and Performance Committee and approval at the Board.

Risk													
Which key red risks does this report address?		**What BAF risk does this report address?**											
Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	x
Financial Risk																		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	x
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Introduction/Background
Accounting standard IAS1, Presentation of Financial Statements, requires each year as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern. The Treasury's Financial Reporting Manual (FReM) interprets the requirements set out in IAS1 as: • *The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern* • *Where a body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties*

must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

The Going Concern Assessment is primarily derived from the historical financial position of the Trust, with an assessment of the future risks, opportunities and uncertainties, including for example any:

- Financial conditions
  - Historic financial performance
  - Future financial plan
  - Cost Improvement/Efficiency savings/ risk assessed delivery
  - Liquidity and ability to meet liabilities
  - Existing borrowing and access to borrowing
- Operating conditions
  - Change in management structures
  - Change in commissioned services
- Risk of non-compliance with Terms of Authorisation

Issues and options

We have reviewed the 2020/21 underlying exit position and are in the process of developing the annual plan for 2021/22 which includes an assumption of the ongoing provision of services. Of significance in relation to going concern are:

- We are a key partner in the Herefordshire and Worcestershire STP which sets out the vision for healthcare services in the two counties in the medium term, and in line with NHS policy is seeking to become an ICS through the NHSE/I assurance process.
- We are actively working with system partners to plan the restoration of services following the COVID-19 pandemic.
- We have received confirmation from NHSE/I that quarter 1 of 2021/22 will be funded on a roll over basis from this financial year
- We will enter into formal contracts for the provision of services for quarters 2-4 2021/22 with once final guidance is available.
- The Trust's bid for £15m of national capital funding over 2 years (2020/21 and 2021/22) to redevelop Urgent and Emergency Care on the WRH site was approved nationally.

<u>Other Financial Considerations</u>

- The Trust has experienced a challenging financial position over recent years, with historic performance showing substantial operating losses as set out below:

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	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	Estimated 2020/21 £000
Breakeven duty in-year financial performance	(25,918)	(59,831)	(28,748)	(52,562)	(68,790)	(80,844)	(2,534)
Breakeven duty cumulative position	(58,436)	(118,267)	(147,015)	(199,577)	(268,367)	(349,211)	(351,745)
Operating income	364,656	368,981	403,348	400,918	411,966	443,722	528,111
Cumulative breakeven position as a percentage of operating income	(16.0%)	(32.1%)	(36.4%)	(49.8%)	(65.1%)	(78.7%)	(66.6%)

- This shows that the Trust is currently forecasting to fail to achieve its statutory duty to break even.
- We have taken out a number of revenue loans over recent years to maintain operational expenditure, but these have been converted to PDC during 2020/21.
- The Trust continues to repay its three Normal Course of Business (NCB) capital loans following the PDC conversion in 2020/21. There will be two repayments due in 2021/22; September 2021 and March 2021 totalling £1.4m.
- The final operational plan once approved will be submitted to NHSE/I, setting out planned income, activity, expenditure and workforce plans. Unless there is a material change in the national funding architecture this is anticipated to reflect a deficit position, and exposure to risks which will require mitigation.
- A key consideration is that we have the cash resources to meet our obligations as they fall due in the foreseeable future. There is a comprehensive cash management and forecasting process in place, including daily, weekly and monthly cash flow forecasting and careful working capital management.
- Access to cash support for PDC funding remains through monthly requests to the Department of Health and Social Care in line with the standard NHSE&I process. To date all requests that have been made in line with national policy have been approved and we have no reason to assume that this support will cease to be made available to the Trust, or that the terms on which cash is provided would change, albeit it is recognised that the current approach creates an element of uncertainty.

Conclusion

Assessment of Going Concern

Whilst we remain in a recurrent financially challenged position, and face a number of risks and uncertainties, there is clear evidence of continued provision of services being planned by both NHSE/I, Commissioners and within the Trust itself.

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On the balance of assessment of the various risks, opportunities and uncertainties, the Chief Finance Officer recommends that the Trust considers itself to be a going concern in line with the accepted definition for public sector bodies. Neither NHSE/I, nor DHSC have deemed the going concern basis to be inappropriate for the Trust.

Recommendations

The Finance and Performance Committee recommend the Trust Board to endorse the Chief Finance Officer's recommendation that the Trust is a going concern. This in readiness for further approval by the Trust Board despite the significant cash requirement within the 2021/22 draft financial plan.

Appendices – Appendix A – GAM extract

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Appendix A – Going Concern Extract – Group Accounting Manual 2020-21

Going concern

4.12. The *FReM* notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

4.13. For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.14. Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate

4.15. Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.16. Where a DHSC group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

4.17. Should a DHSC group body have concerns about its “going concern” status (and this will only be the case if there is a prospect of services ceasing altogether) it must raise the issue with its sponsor division or relevant national body as soon as possible

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Trust Management Executive

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	Martin Wood Deputy Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to receive this report for assurance.

Executive summary	This report gives a summary of the items discussed at the Trust Management Executives (TME) held in January and February 2021. Members will see that there is a clear line of sight between the Board, Committees and TME.

Risk			
Which key red risks does this report address?	*N/A*	**What BAF risk does this report address?**	*N/A*

Assurance Level (x)	0	1	2	3	4	5	6	7	N/A	X
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*									

Action						
Is there an action plan in place to deliver the desired improvement outcomes?					N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

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Introduction/Background

TME is the primary executive decision making body for the Trust. It is set up to drive the strategic agenda and the business objectives for the Trust. It ensures that the key risks are identified and mitigated as well as ensuring that the Trust achieves its financial and operational performance targets.

Issues and options

Since my last report at the November 2020 Board, TME has met twice, on 20 January and 17 February 2021. This report covers both meetings.

January TME

Items presented which were then considered by the Finance and Performance Committee (January)

- COVID-19 Update
- Single Improvement Methodology Business Case
- Xerox Extension and Management of Legacy Records Contract
- Integrated Performance Report
- Finance Report Month 9

Items presented which were then considered by the Quality Governance Committee (January)

- COVID-19 Update
- Nursing and Midwifery Staffing Report – October – November 2020 with a situation report 13/01/2020 of the response for the Covid 19 third wave.
- Ockenden Report
- IPC Update – January 2021
- Integrated Performance Report

Items presented which were then considered by the People and Culture Committee (February)

- Nursing and Midwifery Staffing Report – October – November 2020 with a situation report 13/01/2020 of the response for the Covid 19 third wave
- Integrated People and Culture Report

Other items

- System wide response to the NHSE/I consultation document on the proposed ICS Governance Arrangements
- HomeFirst Worcestershire – Terms of Reference

February TME

Items presented which were then considered by the Finance and Performance Committee (February)

- COVID-19 Longer Update
- Integrated Performance Report
- Finance Report Month 10
- Going Concern

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Items presented which were then considered by the Quality Governance Committee (February)

- COVID-19 Longer Update
- Moving the Patient Experience 4Ward: Front of House Patient Advice and Liaison Service (PALS) Business Case
- IPC Update – February 2021
- Nursing and Midwifery Staffing Report – December 2020- January 2021
- Mortality Review/Learning from Deaths
- #CallMe
- Sepsis Performance Update
- Safeguarding Update
- GIRFT Reset Post COVID (Phase 1)
- Year 3 Quality Priorities – Status - January 2021 and Quality Account Production Progress
- Integrated Performance Report
- Mandatory Training Compliance - Proposal

Other items

- Single Improvement Methodology - Draft Service Specification
- UEC Business Case Update
- Moving the Patient Experience 4Ward: Front of House Patient Advice and Liaison Service (PALS) Business Case
- Update on Annual Planning 2021/22
- Maternity SIs
- Procurement – Transformation Plan Update
- Allscripts Digital Care Record Change Control Notice (CCN) extension request and Health and Wellbeing Conversations PAS/DCR status update
- Review of Terms of Reference
- CQC Maternity Services Inspection Report

Conclusion

Recommendations

The Trust Board is requested to receive this report for assurance.

Appendices