County Durham and Darlington NHS Foundation Trust

University Hospital North Durham

Inspection report

North Road
Durham
DH1 5TW
Tel: 01325380100
www.cddft.nhs.uk

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Ratings

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

Our findings

Overall summary of services at University Hospital North Durham

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at University Hospital of North Durham (UHND).

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

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

University Hospital of North Durham is one of four sites for maternity services for the trust. Acute maternity services are also provided at Darlington Memorial Hospital. Outpatient maternity care is also provided at Bishop Auckland and Shotley Bridge Hospitals, although we did not inspect these services.

We carried out a short notice unannounced focused inspection of the maternity services at University Hospital of North Durham and Darlington Memorial Hospital, looking only at the safe and well-led key questions.

The inspection was carried out using a data submission and an on-site inspection where we observed the environment, observed care, spoke with women and birthing people and their partners who used the services, and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visits, we conducted interviews with specialist staff and senior leaders and reviewed feedback from women and families about the trust. We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends. Feedback included 8 positive and 12 negative experiences. There were some negative comments about staff attitude and long waiting in the pregnancy assessment unit (PAU).

The service at University Hospital of North Durham comprises of a labour ward with 16 labour, delivery, recovery and postnatal (LDRP) rooms, a maternity theatre, induction of labour beds and some enhanced recovery rooms. There is a 23 bed postnatal ward and an antenatal ward (ward 61) incorporating an early pregnancy assessment unit with some triage facilities. The service also has maternity services at Darlington Memorial Hospital and pregnancy assessment units at Bishop Auckland Hospital and Shotley Bridge Hospital which provide services to women and birthing people from across the County Durham area. Antenatal and postnatal clinics are also provided at this location.

The trust carried out 4500 deliveries between April 2021 to March 2022, of which about 3000 were carried out at University Hospital of North Durham and 1500 at Darlington Memorial Hospital.

A lower proportion of mothers were Asian or Asian British (3%) or Black or Black British (1%) compared to the national averages (14%) and (6%) respectively. More women and birthing people who used the service were White (86%) compared to 67% nationally.

Our findings

Our rating of this hospital went down because:

The service was last inspected in 2019 (as maternity as a standalone service) and rated as good in all five domains.

Our rating of the maternity service impacted on the rating for the hospital location overall. As a result ratings for safe and well-led went down to requires improvement and services at University Hospital North Durham are rated as requires improvement overall.

We also inspected the maternity service at Darlington Memorial Hospital run by County Durham and Darlington NHS Trust.

Following the Care Quality Commission (CQC) inspection of both County Durham Hospital and Darlington Memorial Hospital the CQC issued the Trust with a warning notice on 28/04/2023. This notice is served to the trust under Section 29A of the Health and Social Care Act 2008. Where it identified that the trust is required to make significant improvements.

How we carried out the inspection

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

Maternity

Inadequate

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

- Not all staff had training in key skills appropriate for their role.
- Staff did not always manage antenatal and intrapartum safety well. Including induction and risk assessment processes.
- The service maintained cleaning records, although these records were not always kept up to date. They did not always demonstrate that all areas were cleaned regularly or that secure areas were always locked.
- Staff did not consistently carry out checks on equipment.
- Staff did not consistently assess risks to women and birthing people, nor act on them.
- Staff shortages increased risks to women and birthing people across the maternity service. Staffing levels did not always match the planned numbers putting the safety of women, birthing people, and babies at risk.
- Women and birthing people could not always access the service when they needed it and sometimes had to wait for treatment. The trust did not audit or monitor time of arrival to triage or time of arrival to review.
- Staff did not always use the trust's systems and processes to safely record and store controlled drugs.
- Staff did not always feel respected, supported, and valued. They were not always able to focus on the needs of women and birthing people receiving care.
- The service did not always manage safety incidents well nor learn lessons from them.
- Leaders did not always have the skills and abilities to run the service for women and birthing people and staff.
- Leaders did not operate effective governance systems. They did not always manage risk, issues and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services, they did not always have the skills and resources to do so.
- Leaders did not always ensure staff were competent. Not all staff had received an annual appraisal and senior leaders did not always support staff to develop their skills.
- Staff did not always use electronic patient record systems consistently.
- Staff had limited awareness and understanding of the service's vision and values and staff were not always able to apply them in their work.
- The service did not always engage well with women and birthing people and the community to take all vulnerable people into consideration, plan and manage services.
- Leaders and managers were not always visible and approachable in the service.

However:

- Staff appraisal rates had recently improved to meet the Trust target.
- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse.
- Staff kept good care records. They administered and kept medicines prescription and administration records well.

Maternity

- Staff were clear about their roles and accountabilities. They were focused on the needs of women and birthing people receiving care.

Is the service safe?

Inadequate

Mandatory training

The service did not make sure everyone completed mandatory training.

Staff were not up to date with their mandatory training. The service provided information that showed staff were required to complete mandatory training, clinical mandatory training, and local mandatory training. Following the inspection the trust provided updated information on staff training compliance. Records showed compliance rates for individual mandatory training courses against a trust target of 95% for core statutory and mandatory essential training and 85% for role specific courses. New compliance rates showed the service across both sites was at 87.7% overall.

However, compliance for role specific courses for midwifery staff across the trust ranged between 50% for hand hygiene and 100% for preventing radicalisation. Midwifery staff achieved the trust target for 1 out of 5 core training and 22 out of 44 role specific courses. Compliance for medical staff ranged between 22% for hand hygiene and 100% for preventing radicalisation courses. Medical staff achieved the trust target for 0 out of 5 core training, and 6 out of 30 role specific courses.

Managers did not always give staff time away from clinical duties to complete training. Staff said managers monitored mandatory training and alerted staff when they needed to update their training. However, they could not complete all the training because of staffing pressures. Staff reported it was a common occurrence of being pulled off internal study days. Staff said they had been advised by managers not to incident report this and it was corroborated by further evidence received.

Following our inspection, the trust provided information specific to Cardiotocographs (CTG) from 31 March 2023 to show compliance rates for staff across both sites had improved to 96% for midwives, 96% for doctors and 92% for consultants. In January to March 2022 compliance data had shown low rates of compliance: midwives 58%, doctors 65% and consultants 62%.

The service ensured all staff received multi-professional simulated obstetric emergency training. Staff could attend 3 study days a year which included simulated obstetric emergency training and life support training and this time was protected. The trust provided information from 31 March 2023 to show compliance rates had improved from previous rates to 92% for midwives, 88% for doctors and 92% for consultants.

The service provided New-born Immediate Life Support Training Level 3. At the time of our inspection, the trust target was 95% and the compliance rate for medical staff was 83%. The annual local training in new-born resuscitation skills compliance rate for advanced nurses was 95% but only 81% for consultants. Compliance for neonatal nurses had improved from 80% to 94%, and junior doctors had improved from 88% to 100%.

Maternity

Staff were supported by practice development midwives to complete mandatory training. Staff told us specialist midwives could not always fulfil their specialist roles because they were often required to support staff shortages in the units.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed safeguarding training at the level appropriate for their role. Ninety-four per cent of medical staff and 93% of midwifery staff had completed safeguarding level 3 training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics. During handover we saw staff made adjustments to meet the needs of women and birthing people such as those living with mental health conditions or difficulties.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic patient records (EPR) system. We saw this recorded in records we reviewed. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence during our inspection that safeguarding concerns were discussed and escalated appropriately to the trust safeguarding team. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the trust's baby abduction policy. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. However, staff said the service had not practised what would happen if a baby was abducted within the 12 months before inspection as identified in the emergency skills and drills training schedule.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment appropriately but did not always document control measures to protect women and birthing people, themselves, and others from infection. They kept most equipment and the premises visibly clean.

Maternity service areas were mostly clean and had suitable furnishings which were clean and well-maintained. Domestics were available on the wards every day, and the environment appeared clean. However, wards had not been refurbished to the latest national standards.

Cleaning records were not always kept up-to-date, and staff could not demonstrate that all areas were cleaned regularly. In the Pregnancy Assessment Unit (PAU) no cleaning records for equipment were available. One audit showed some items of equipment such as computer trolleys had been found to be dirty or dusty. During the inspection we found some equipment including the drug round trolley and resuscitation trolley in the antenatal ward were not clean. We found daily cleaning checklists for equipment that had not been completed for any of the first 21 days of March 2023.

Staff told us they used 'I am clean' stickers but we did not see these used in practice during the inspection.

Dirty utility rooms throughout the unit were not locked. There were keypads to enable locking of the doors, but staff explained these were left open for quick and easy access to the sluice areas. Cleaning chemicals were kept on worktops or in unlocked cupboards within the utility rooms. We found a cupboard containing cleaning items was locked but the keys had been left in the lock. These issues were escalated to ward staff during the inspection. Staff were unable to provide risk assessments to show these had been addressed.

The housekeeping area on the postnatal ward was cluttered with kitchen items.

The service generally performed well for cleanliness. Cleanliness audits for the 3 months prior to our inspection showed all areas met the compliance rate of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Ward managers completed regular Back to Basics IPC Audits that included infection prevention and control and hand hygiene checks.

In the last year IPC compliance ranged from 91% to 98%. Records showed rooms and equipment including mobile resuscitaires had been checked daily. Staff told us they cleaned everything immediately after use. However, checklists were not kept with equipment but stored in a folder at the nurses' station. It was not apparent how staff would know if a piece of equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises, and equipment did not always keep people safe. The layout of the pregnancy assessment unit (PAU) was not an appropriate environment for women and birthing people to wait for clinical input. However, staff managed clinical waste well.

There was poor compliance with emergency equipment checks. For example, we found the PAU emergency resuscitation trolley top was dusty and the sepsis box had a loose lid. Records showed that the resuscitation trolley on labour ward was not checked every day and no checks were documented between 1 March and 21 March 2023.

Clutter and housekeeping issues on Ward 8 were identified and raised with staff during the inspection and we observed these were remedied immediately.

The inspection team found equipment was not always stored safely. The lists of contents for the Post-Partum Haemorrhage (PPH) trolley and eclampsia trolley were not dated to show when they were last reviewed. Daily checks for emergency trolleys throughout the unit were incomplete with gaps identified between December 2022 and March 2023, and in one case no check sheet was available for the whole of February 2023.

We found gaps in the flooring around the bed area in one of the labour rooms. Staff said it was “very difficult to clean this area, particularly after an instrumental delivery”. Other labour rooms had the same flooring but no gaps and these were filled with a solid sealant. The inspection team raised this with a senior midwife who advised that they would report the flooring issue to estates and ask for the gaps to be filled.

Women and birthing people could reach call bells and staff responded to the person's needs in a timely manner. We saw midwives answered call bells on wards and labour ward. However, we received feedback from women and birthing people following our inspection who told us they waited for lengthy periods for call bells to be answered at night. Staff aimed to use rooms close to the midwives’ station for women with additional needs.

There were CTG machines for each labour, delivery, recovery, and postnatal (LDRP) room. Not all CTGs were equipped with Dawes Redman monitoring which did not meet Ockenden report (2020) requirements. Cardiotocography is usually called a 'CTG' by doctors and midwives. It can be used to monitor a baby's heart rate and a mother's contractions during pregnancy. Staff told us they were aware the equipment did not meet recommendations but had been told there were no funds available to replace existing CTG machines. There was central observation monitoring equipment at the nurses’ station as well as computer access to CTGs. During and following the inspection we raised this with the trust. Trust leaders responded and told us additional CTG machines equipped with Dawes Redman monitoring had been ordered following the inspection.

There was a pool evacuation net and evacuation guidelines in the pool room. Staff told us there had not been an evacuation drill in the last 12 months. However, managers said a skills drill was booked.

The service had suitable facilities to meet the needs of women and birthing people's families. Rooms on labour ward were designed and equipped for labour, delivery, recovery, and postnatal care (LDRP). The birth partners of women and birthing people were supported to attend the birth and provide support.

At the time of the inspection, there were inappropriate bereavement facilities on both sites. Bereaved families stayed on labour ward in rooms that were not soundproofed or in an isolated area for privacy. However, staff told us refurbishment of a new bereavement room was underway and due to be completed within a few weeks of the inspection.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal. However, we found one pharmacy waste container which was overfilled. We informed a manager and the container was disposed of safely and replaced immediately.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and birthing person, and staff did not always take action to remove or minimise risks. Therefore, staff were not always able to identify and quickly act upon women, birthing people, or babies at risk of deterioration.

Leaders did not monitor patient waiting times and leaders could not be assured that women and birthing people could access maternity services when needed or receive treatment within agreed timeframes and national targets.

Maternity

During the inspections we found there was no standard process for documenting arrival times when women and pregnant people attended triage. Prior to February 2023, triage staff had recorded arrival times in a paper desk diary. However, staff told us due to pressures caused by shortages of qualified and experienced staff, they had been asked by managers to stop recording arrival times. There was no review or audit to show how long women waited for triage or review.

Staff told us all the information gathered from telephone triage and consultations would be entered onto the electronic patient record system (EPR). However, the staff in Pregnancy Assessment Unit (PAU) did not have full oversight of whom had telephoned or had been advised to come in, who was attending, and how long they were waiting for care.

At the time of the inspection there were ineffective processes to ensure women and birthing people arriving in the PAU were assessed on arrival to the unit. Trust board papers of May 2022 stated, "patients in Pregnancy Assessment Unit (PAU) will not have observations completed in the trust's electronic system until admitted as an 'in-patient'". Staff told us, and records showed, patients attending triage during the inspection did not always have observations recorded during their time in triage. Without initial observations and an initial assessment, there was a risk that deterioration in women, birthing people, or babies would not be recognised and acted upon.

Staff used a recognised tool known as the Modified Early Obstetric Warning Score (MEOWS) tool to monitor women and birthing people using maternity services. However, staff did not always carry out clinical observations using the MEOWS tool in a timely way, record them, or escalate them appropriately. This meant that there was a risk of women, birthing people, and babies coming to harm. MEOWS audits from the 3 months between December 2022 and February 2023 showed 62.5% of women scored above '0' on MEOWS indicating further action was required. Of those, 33% of observations were not taken in line with the appropriate frequency following local and national guidance. Also 47% of scores meeting the MEOWS trigger were not escalated according to trust policy.

Midwives completed records using the electronic patient record at booking and during antenatal care. Risk assessments were completed following prompts from the electronic record system. The service told us following the inspection an audit from February 2023 showed 99.5% completion. However, at the time of the inspection, there were no formalised risk assessments in line with national guidance to support staff to care for women and birthing people attending for triage at the Pregnancy Assessment Unit (PAU) . The systems used within the triage unit were not adequate to keep women, pregnant people and babies safe. Not all clinical interactions were recorded, and no formal prioritisation tool was available to assist staff in providing timely care to those in most clinical need. We told the trust they must ensure women and birthing people were appropriately monitored and timely risk assessments were carried out in triage. Following the inspection, the trust told us they had implemented a risk assessment process.

We observed women and birthing people in the PAU waiting area. Women and birthing people attending for triage or PAU sat out of sight of staff while they were waiting. This meant a deterioration of the women or birthing people may not be recognised and care and treatment could be delayed. We provided feedback about this to senior staff immediately after the inspection. The trust provided information on action taken to risk assess this and make improvements, including provision of additional staff and creating a formal waiting area with call bells installed.

Staff did not always complete risk assessments for each woman or birthing person during pregnancy or in the intrapartum period (around the time of labour and delivery of a baby), using a recognised tool, or review this regularly, including after any incident. There was no evidence-based, standardised risk assessment tool except for prompts provided through the electronic patient record (EPR). Staff explained the EPR was not always completed contemporaneously so any prompts provided were not always available to staff at the time of clinical need.

Maternity

Staff did not always complete risk assessments prior to discharging women and birthing people and pregnant people into the community and did not always make sure third-party organisations were informed of the discharge.

Newborn Infant Physical Examination (NIPE) was described as a “bone of contention” and babies' discharges could be delayed awaiting this examination as not all midwives could complete a NIPE and there was a reliance on the paediatricians to complete the these. Medical staff were not routinely rostered to ensure NIPE was carried out which meant there were delays.

Some women and birthing people experienced delayed inductions, and some did not receive induction of labour, although it had been planned for clinical reasons. As a result, women, birthing people, and babies were put at risk of harm. During the inspection we observed women and birthing people awaiting induction of labour were backlogged from the previous day, and further inductions were planned to attend that day as scheduled. Staff told us it was common for inductions of labour to be delayed. These delays regularly lasted 24 hours and sometimes lasted for 2-3 days. We observed safety huddles where staff discussed workload and acknowledged delays in inductions of labour.

There were 93 incidents reporting delays in inductions of labour recorded by staff from both sites between 20 January 2022 and 20 January 2023. Patient records showed some women had waited for several days, and in one case for over a week, or had no induction at all, even when records showed acknowledgement of clinical risk and trust guidance. We found evidence harm had occurred to mothers and babies when the trust did not take action and inductions were delayed or not carried out.

Staff did not always escalate concerning CTG features in line with trust policy or protocol. CTGs were not always reviewed in line with local trust policy and not always interpreted correctly. Staff did not always carry out second review (‘fresh eyes') at appropriate times during monitoring in line with local trust policy. Trust audit results showed CTG ‘fresh eyes’ check compliance had deteriorated in the 3 months prior to our inspection and ranged from 85% in January 2023 to 74% in March 2023. During our inspection we found multiple examples of incidents reported, and through audit where CTG findings had not been escalated and actions were not taken to avoid possible harm. Out of 17 investigations carried out by the Health Safety Investigation Branch (HSIB) 18th March 2019 – 14th March 2023, 5 cases were identified as having errors or care issues relating to CTGs. This meant women, birthing people and babies were not risk assessed or managed appropriately to reduce the occurrence of harm.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. In the records we reviewed these were completed by clinical staff via the electronic patient record system (EPR).

Staff shared key information to keep women and birthing people safe when handing over their care to others. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff held 2 safety huddles during each shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, and recommendation for each patient.

Maternity

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. However, audit showed these were not always completed at appropriate times or according to trust policy. Some babies were readmitted to the unit or had prolonged stays in hospital. The trust did not provide evidence of plans to reduce "avoiding term admissions into neonatal units" (ATAIN).

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

We found there were missed opportunities for carrying out screening and for managing results of screening to safely manage care during pregnancies of women, birthing people and babies. There had been 76 incidents between January 2022 and January 2023 reported as 'near misses' or 'minor harm' that showed staff had not complied with guidance from pathology such as labelling protocols and guidance from national screening standards There were 6 of these that remained open or were awaiting a review in January 2023.

Midwifery Staffing

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

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day we inspected the service, we observed there was 1 midwife in the pregnancy assessment unit when there should have been two registered midwives. During the inspection, 1 midwife was seen to care for 6 complex high-risk women and pregnant people in the antenatal area of pregnancy assessment unit (PAU) in addition to answering the triage telephone, booking scans and caring for women and pregnant people arriving and waiting in the PAU. Leaders advised that no acuity tool was being used in the PAU or ward areas.

Staffing establishment in relation to acuity was met at University Hospital North Durham for 68% of shifts during January 2023. However 30% of shifts showed the trust to be up to 2 midwives short on staffing establishment, and to be more than 2% short, with 16 episodes (90 hours) recorded of midwives being redeployed.

The service did not use an acuity tool in all areas. Acuity was not measured on the postnatal ward, however there were "many" occasions when there was 1 midwife allocated to the postnatal ward (Ward 10) and that midwife was responsible for caring for 13 mothers and babies. The trust had not identified how many registered midwives should be on shift but were using a staff allocation tool. However, however this tool was not specific to maternity care.

During the inspection we found the service was consistently short of registered midwives across all areas. Staff shared that it was a normal occurrence for inductions of labours to be delayed due to staffing issues.

There was not always senior midwifery supernumerary oversight on labour wards. Although labour ward coordinators were planned to be supernumerary staff told us this rarely occurred in practice, and coordinators took responsibility for direct care. The Maternity Surveillance Report for Maternity Safety Champions Meeting' (March 2023) recorded 10 occasions (6 in January and 4 in February) when the labour ward co-ordinator was not supernumerary.

Skill mix was not always in line with national recommendations. Staff told us they had raised concerns that Band 5 newly qualified midwives were working night shifts on labour ward to fill shifts. Staff told us it was common practice to

relocate the second midwife from the pregnancy assessment unit to the labour ward and sometimes staff from the Darlington Memorial Hospital were also relocated to work in the labour ward. Staff shared that staff relocations were to be recorded on the staffing allocation tool. However, not all shifts were recorded accurately on the staffing allocation tool.

Pregnant women and birthing people did not always receive 1:1 care during labour in line with national guidance National Institute for Health and Care Excellence: QS205 (2017). Incidents recorded showed staff had reported when women had not received 1:1 care and when treatment or procedures had been delayed due to shortage of registered midwives on shifts.

Leaders recognised the service was unable to offer home births due to staffing shortages. However, the trust website continued to list homebirth as an option for women. Staff told us they knew women who had been very disappointed this option could not be offered and anecdotally women were opting to have an unassisted or freebirth (unassisted birth is sometimes called 'free birth'. It means deciding to give birth at home or somewhere else without the help of a healthcare professional such as a midwife). Midwives and representatives from the local maternity voices partnership told us the number of women opting for freebirths was increasing, mainly because they could not have a midwife-assisted homebirth. The trust recorded numbers of babies “born before arrival” at hospital and these rates had steadily increased. Staff explained freebirths would be included in these figures.

Staff told us that the pregnant women and birthing people did not always receive 1:1 care in labour due to staffing. However, the proportion of 1:1 care in labour achieved was not recorded in trust board papers or senior staff reports. Staff told us low numbers of staff made them feel unsafe. Staff had reported delayed inductions of labour through the incident reporting system and these included babies categorised as high risk. Between September 2022 and February 2023 there had been 144 delayed inductions of labour reported in trust board papers. The service’s March 2023 Maternity Surveillance Report for Maternity Safety Champions Meeting reported in January 2023 documented examples of delayed inductions of labour and where staff identified clinical guidance had not been followed regarding appropriately timed inductions of labour.

During our inspection the ward manager did not have the resources to adjust staffing levels according to the needs of women and birthing people. Managers told us this happened daily, and they regularly moved staff according to the number of women and birthing people in clinical areas, Midwives told us this happened at short notice, and they were frequently expected to work in areas unfamiliar to them.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 (2015) ‘Safe midwifery staffing for maternity settings. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. During the inspection’ staff told us, and we found staff did not report staffing incidents that should have raised red flag indicators that included delays to inductions of labour, delays with LSCS (lower segment caesarean section), delays of induction of labour for 2 hours or more between admission and beginning of the process. We found there was delayed recognition of, and action on, abnormal vital signs and lack of assurance that women were being seen for triage within 30 minutes of presentation.

Staff told us many issues relating to staffing were reported continually to managers and leaders, but these seemed to be ignored. Midwives had communicated their concerns to managers over the previous 12 months and had stated they found the unit was unsafe. However, staff told us nothing had changed. Staff told us they regularly missed breaks, worked late, and worked extra hours (both paid and unpaid), and midwife sickness levels were very high due to the increased pressure on staff because of shortages in staffing.

Staff told us they should be given their off-duty rota 4 weeks in advance but sometimes managers now provided these only 2 weeks in advance. Staff said this was insufficient time to plan for their shifts. However, NHS Improvement advises publishing rosters a minimum of six weeks in advance, ideally 12 weeks. (NHS Improvement, 2019).

Midwifery staffing summary from open board meetings evidenced that the service had high vacancy rates, turnover rates, sickness rates, and high use of bank nurses. Despite the use of bank staff there remained 75 shifts unfilled between September 2022 and February 2023.

The trust and service leads said they were actively recruiting locally, regionally, nationally, and internationally to meet their establishment and backfill using bank and agency staff. However, it was unclear as to what the trust correct staffing levels should be. Board papers from August 2022 showed an established acuity assessment tool was awaiting reassessment and there was no evidence to show this had been completed by the time of the inspection.

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

The service made sure all new staff completed competency assessments. Managers told us they supported staff to develop through yearly, constructive appraisals of their work. A practice development midwife supported multidisciplinary staff development.

The trust target for staff appraisals was 95%. Compliance data showed all medical staff (100%) and 96% of midwifery staff had completed an annual appraisal. This was a significant improvement from the maternity surveillance report from the maternity safety champions meeting in March 2023 which showed lower rates of compliance for January 2023 at 40%.

Staff said midwifes no longer received supervision but relied on the appraisal system to ensure competency. Staff told us they felt this was not as effective as supervision. The lack of supervision for midwifes should be separate from the appraisal process and this was not in line with national recommendations from Royal College of Midwives, Midwifery Standard 33: There must be a framework for effective and accessible clinical supervision. However, midwives told us they were supported in professional development and had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

Managers did not always make sure staff received specialist training for their role. Training provided included role specific training which showed a range of compliance for midwives, doctors and consultants as reported under the mandatory training section of this report.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number and provided the required consultant hours for the service. The service had low vacancy, turnover and sickness rates for medical staff.

Maternity

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locum doctors told us they were well supported and received a comprehensive induction.

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

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

Managers supported medical staff to develop through regular and constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

Trainees in a GMC approved training post in the UK complete the 2022 General Medical Council National Trainee Survey (GMC NTS) regarding the quality of training received, support and wellbeing. Scores for this hospital were significantly below (worse) than the national average for the indicator Facilities, and significantly above (better) than the national average for the indicator Clinical supervision out of hours.

Records

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

In most clinical areas women and birthing people's notes were comprehensive, and all staff could access them easily. However, on PAU staff told us and records showed, not all clinical interactions were recorded at the time of activity. This included information required for each woman and birthing person on arrival, and no risk assessments were documented at this time.

The trust used electronic patient records. The patient care record was on a secure electronic patient record (EPR) system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

We reviewed 10 electronic records and found records were clear and complete.

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

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

Medicines

The service mostly used systems and processes to safely prescribe, administer, and record medicines. However, they did not always keep controlled drugs documentation in line with regulations or store all medicines safely.

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

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

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

Staff stored and managed medicines and prescribing documents safely. The clinical rooms where the medicines were stored were locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperatures.

There were gaps in documentation in the controlled drug register book on the labour ward between 25 December 2022 and1 March 2023. The controlled drug order book showed "received by" signatures were not always completed, indicating there was a poor medicines management process. Staff did not check controlled drug stocks daily.

The controlled drug register identified weekly stock checks had been completed. However, some patient identification details were missing. There were gaps for signatures and times when medicines were given. Start times for epidural fluids and dose information for epidural bags was not recorded. There was no evidence that a pharmacist had checked the ward stock and there were no checks or assurance entries entered.

We found some emergency trolleys and grab boxes contained insulin, adrenaline, or controlled drugs; (intravenous diazepam and rectal diazepam). But these had no tamperproof tags, so staff would not know if trolleys had been opened and contents used or taken. We raised this with ward managers at the time of the inspection.

Staff monitored and recorded most fridge temperatures and knew to take action if there was variation. However, there were gaps in the monitoring of the medicine fridge temperature checks on the antenatal ward. This fridge was used for storage of temperature sensitive medications for induction of labour. The daily checks identified a significant number of gaps, for example only 6 fridge checks were documented for the first 28 days of March 2023, of which only 1 minimum and maximum temperature check had been recorded. The February 2023 checklist identified only 7 checks had been recorded with minimum and maximum temperatures recorded on 6 of those occasions. No ambient room temperatures were recorded, and the fridge contained items and was very full giving concerns as to the effectiveness of the fridge's cold storage.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems were fully completed, accurate and up to date.

Staff learned from safety alerts and incidents to improve practice. These were shared in daily safety huddles, via emails and lessons learned were included in staff bulletins.

Incidents

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. However, managers did not always review incidents in a timely way and duty of candour was not always applied when things went wrong.

Maternity

Staff could describe what incidents were reportable and how to use the electronic incident reporting system. Although managers reviewed incidents using the trust's root cause analyses tool (RCA), these reviews did not always recognise failings in care which may have had an impact on the outcome for babies, or for babies which sadly died. The trust did not have an open, accurate, effective, robust review of risk process and there was a lack of evidence lessons are learnt despite poor outcomes as reported in HSBI investigations and PMRT cases since 2019. PMRT reviews were not always completed and trust staff cited "no consent" as the reason. However, consent is not necessary for internal reviews or PMRT to be carried out.

Incidents reported were not always reviewed or acted upon in a timely manner. The potential for learning lessons from incidents, lack of immediate actions, and further action planning meant opportunities were missed to prevent women, pregnant people, and babies being exposed to harm.

Managers did not always investigate incidents thoroughly. Incidents were not always reviewed in a timely manner to monitor and manage risk, and identify opportunities for learning or changes in practice to reduce the recurrence of harm. We found 212 maternity incidents remaining open for over 60 days. Data regarding open incidents from 30 March 2023, showed there were incidents dating back to October 2021 that were awaiting review or closure. There was a lack of evidence of actions being taken to address themes, assess and manage risks, and implement change. For example, reported incidents included management of post-partum haemorrhage, delays in treatment, clearly documented information about allergies not followed, and safety measures ignored. There was not always evidence to show learning from these had been investigated and shared. This was seen in recurrent findings and recommendations for example from HSIB reports. Following some reports, HSIB action points were documented as completed. However, some of these actions remained incomplete and continued to put women, birthing people, and babies at risk.

Staff understood the duty of candour. However, they were not always open and transparent and did not always give women and birthing people and families a full explanation if and when things went wrong. It was not clear duty of candour was always applied when it should have been. We reviewed serious incident investigations and found staff had not always involved women and birthing people and their families in the investigations. Perinatal Mortality Review Tool (PMRT) review documents noted families had provided feedback to show there was a lack of support and information provided, and a limited number of cases shared families' perspectives with staff. Maternity staff were not able to recall any instances where duty of candour had been carried out.

We found serious incident reviews that showed a lack of evidence Duty of Candour and PMRT had been carried out where the trust had identified care may have caused harm, such as stillbirths, neonatal deaths, or brain injuries to babies. However, examples provided by the service of two serious incident records showed evidence that Duty of Candour had been carried out.

Managers did not always review incidents potentially related to health inequalities. One HSIB investigation noted a case where staff had not acknowledged a woman or birthing person's needs when antenatal records showed they lived with a learning disability.

Local managers debriefed and supported staff after any serious incident. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. However, staff said they did not always receive feedback from investigations of incidents they had reported or from serious incidents, mainly because they were not reviewed for several months.

Managers met weekly to discuss the feedback and look at improvements to the care of women and birthing people. Staff explained, and incident reviews showed, there was limited meaningful action and improvement following feedback.

Maternity

Is the service well-led?

Inadequate

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

Leadership

Local leaders did not always have the skills and abilities to run the service, they were not always visible and approachable in the service for women, birthing people and staff. Executive leaders did not always manage the priorities and issues the service faced. However, leaders supported staff to develop and take on more senior roles.

The service was led by a head of midwifery, clinical director and business operations manager. This triumvirate reported to the executive director of nursing and medical director. Leaders did not always have the skills and abilities to run the service. They understood the priorities and issues the service faced although these issues were not always addressed or shared with staff.

Leaders had been aware of patient safety risks and challenges throughout the service for a prolonged period of time. Leaders had not completed or taken all essential actions to ensure the safety, quality, and sustainability within the service.

Staff voiced concerns that they felt the unit midwifery staffing was 'unsafe' and this was repeated throughout the inspection. Although the trust had developed 'time to talk' sessions, staff told us these were affectionately known as 'time to listen' and that these were completed only as a tick box exercise.

Staff reported that leaders were not always visible and approachable for women, birthing people, and staff in the service. Leaders were not always respected, although some senior staff described them as approachable. Staff reported them lacking in providing supportive responses. Staff said leaders "appeared" supportive. However, no tangible improvements were made, despite issues repeatedly being raised to the leadership team.

Staff told us they were supported by their line managers, ward managers and matrons. They said the executive team visited wards and staff spoke of how they had been more accessible around the time of the inspection. The service was supported by maternity safety champions and non-executive directors.

Vision and Strategy

The service leaders had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, not all staff felt their views had been taken into consideration and could only give limited explanation of what it meant for the service and local women. Although leaders understood and knew how to apply them and monitor progress, staff did not understand the service strategy.

The trust leaders had developed a vision and strategy in relation to maternity continuity of carer (MCoC) model of care and had implemented this. This model is a way of delivering maternity care so that women and birthing people receive dedicated support from the same midwife throughout their pregnancy. However, ward staff could give limited explanations regarding the trust's vision, and what it meant for women and birthing people and babies. Staff in the

acute areas we visited told us they felt their views were not taken into consideration. Most ward staff told us they felt staff engagement had not been done fairly and they felt that not all staff views had been considered. Leaders had carried out a staff consultation, but most staff felt this had not been done fairly. Leaders provided survey results that showed most staff would have preferred to review the plans for implementing 'continuity of carer' as a group, but these responses were combined amongst other responses and not all had been considered. Although, leaders stated the survey results had not been conclusive, the plans had gone ahead.

Staff reiterated they felt that 'continuity of carer' was the trust's main focus, despite depleted safe staffing levels, skill mix, and staff being pulled in to cover acute areas on a frequent basis. The trust's implementation of 'maternity continuity of carer' (MCoC) was not in line with national recommendations as they could not demonstrate staffing levels met safe minimum requirements on all shifts. These recommendations were shared nationally in September 2022. Senior leaders advised that the trust had considered these recommendations, but had decided to continue with MCoC, albeit in a scaled back form compared to original plans. Staff told us and incidents reported showed there were inequalities and disadvantages for women not on the MCoC pathway. For example, when there were insufficient staff to provide induction of labour for women in the acute setting, one woman on the MCoC pathway had an induction carried out by her MCoC midwife. This meant one woman had an induction of labour based on availability of her midwife, before others at higher level of risk could have their planned induction of labour.

Culture

The service did not have an open culture where staff could raise concerns without fear.

Leaders were not responsive, staff said they felt leaders had been dismissive when issues had been raised with them. Staff reported feeling 'frozen out' or that their concerns were ignored by leaders, as a recurrent issue with the leadership team since 2020. This was indicative of a "closed culture". CQC defines a closed culture as "a poor culture that can lead to harm, including human rights breaches such as abuse". In these services, people are more likely to be at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture.

Staff told us they felt their concerns were not listened to by the leadership team. Staff said responses from the leadership team appeared supportive. At the time of the inspection staff told us that although active recruitment was ongoing, they felt no tangible improvements were made despite issues repeatedly being raised to the leadership team. However, following the inspection and our feedback to the senior executive team, the service provided information to show they had begun new work and continuing workstreams to address underlying service issues and challenges which sought to engage midwifery teams.

Staff promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Staff were focused on the needs of women and birthing people receiving care, demonstrating kindness, compassion, and courage.

Dignity and respect for people accessing maternity services were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

We observed good working relationships throughout the multidisciplinary team. Staff felt there were good working consultant relationships and midwifery staff felt confident to challenge medical staff, although acknowledged that there were mixed approaches from the consultants who worked with differing styles and to "different protocols". This included interpretation of the consultants using a standardised venous thromboembolism (VTE) risk assessment guidance.

Maternity

The service promoted equality and diversity in daily work. Leaders understood and acknowledged how health inequalities affected treatment and outcomes in their local population. However, the service did not have effective systems to demonstrate how this was monitored or managed to improve maternity services.

Women, birthing people, and their families we spoke with said they knew how to complain or raise concerns and felt that they would be listened to. The service used the most informal approach applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The trust provided complaints information that showed 3 formal complaints were received between January and March 2023. Of these, all were awaiting outcomes. Managers investigated complaints and identified themes. However, staff said they did not receive feedback from cases other than newsletters and group emails. There was a lack of regular staff team meetings to communicate issues and feedback on outcomes and learning from complaints.

Governance

Leaders did not always operate effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities but they did not have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate an effective governance process throughout the maternity service. The service provided a clear governance structure and processes to support the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics although there was a lack of evidence of lessons learnt and subsequent improvements to practice. Therefore, there was not a comprehensive well-structured governance process embedded.

The trust had not met the “Ockenden 7 national immediate essential actions from December 2020”. The trust action plan from March 2022 in response to the Ockenden report statement “Women were not formally risk assessed at every antenatal contact to ensure continued access to care provision by the most appropriately trained professional” showed the trust were not yet compliant with this point and the head of midwifery would continue to monitor and maintain standards through audit. Audit results were provided by the service following the inspection. Leaders said they had considered the recommendations from the Ockenden 2020 and 2022 reports and said they planned to revise the vision and strategy to include these recommendations.

Key concerns identified from Ockenden 2020 and 2022 report recommendations were workforce, embedding twice daily ward rounds, implementation of PMRT, audits, and lack of risk assessments (to include place of birth). At the time of our inspection the service had no triage risk assessment tool and had not evidenced that they were compliant to Saving babies Lives version 2 (published March 2019). At the time of our inspection, not all actions in line with recommendations had been implemented. However, the service provided an updated Ockenden Action Plan as presented to the Board in January 2023. This showed they were partially compliant with “A risk assessment must be completed and recorded at every contact".

The trust did not always review or act upon incidents in a timely way. As of 30 March 2023, there were 212 incident cases remaining open for over 60 days, including incidents from October 2021 that continued to await review or closure. Leaders told us staff were encouraged to report incidents for understaffing. However, staff told us it was their perception they were advised by senior staff and discouraged from incident reporting relating to training being cancelled, staff being redeployed to alternative clinical areas, and understaffing.

Maternity

Learning from serious incidents was not always embedded. We found there were 2 cases presented by the trust paediatric service to the trust board in 2023 which shared the same themes previously identified by HSIB and PMRT as evidenced in HSIB reports dating back to 2020 with repeated safety recommendations and actions required.

Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. However, information was not shared back to sub-committees or to all staff.

Maternity service leaders were not always able to describe accurately the status of audit programmes or audit results, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvement.

The service's governance and risk processes were not effective in identifying failings, learning from incidents, or evidencing changes to practice to prevent recurrence. Incidents reported were not reviewed or acted upon in a timely manner to monitor and manage risk and identify opportunities for learning or to implement changes in practice to reduce the risk of harm.

We found reports relating to compliance with national guidance and report recommendations where the trust had assessed themselves as compliant, partially compliant, or actions had been met. These included external reports, national guidance, and recent reviews including the Ockenden Trust Assurance Report and the Kirkup East Kent Hospitals report. However, we found instances where information contained within these was not correct, and different information had been reported in board papers, in manager's meetings and through interviews with senior staff. For example: trust board papers from February 2023 showed the trust was not compliant with 2 of 10 actions under the Maternity Incentive Scheme 2022. This scheme is designed as a financial incentive to support the delivery of safer maternity care.

We reviewed data and figures from the service's maternity dashboard and found there were errors and inaccuracies in the calculations, totals, and omissions including months with missing information and data. Therefore, we were not assured that the correct data was being collated, recorded and reported within the service, and to the board. Dashboard information included the number of "Babies Born Before Arrival" (BBA). Following the inspection the service reported there had been 33 BBA cases in the 11 month period to February 2023. However, we found no recognition of BBAs in meeting minutes, action plans or communications with staff.

Staff were clear about their roles and accountabilities, but they did not have regular opportunities to meet, discuss and learn from the performance of the service or incidents. For example, actions and lessons learned from PMRTs and HSIB investigation recommendations.

Management of risk, issues, and performance

The trust did not use effective systems to manage performance effectively and safely. They did not always identify and act to minimise risks and issues relating to safe care of women, pregnant people, and babies. The leaders did not complete and ensure changes in practice were made as agreed from action plans to improve safety and performance.

The service had a risk register to address service risks such as concerns around staffing and estates but not all risks discussed with the inspection team were included in the register such as escalation of clinical risk. Not all risks the

service were aware of were effectively managed using this process. Therefore, the risk register could not provide assurance to the trust that it was fit for purpose. Leaders had presented risks through the board assurance framework including risks regarding workforce, estate, and items raised during the inspection such as ligature risks. This was recorded in the trust board open paper for 29 March 2023.

Leaders did not have an established clinical risk process and did not have full oversight of all risks to patient safety. Following reports and recommendations from investigations carried out by the Healthcare Safety Investigation Branch (HSIB) there was a lack of effective tangible actions evidenced and lessons learnt.

Leaders did not always identify and escalate relevant clinical risks, issues, or actions to reduce their impact. Staff told us not all risks were identified through the incident management system and risks were not always reviewed and recorded in meeting minutes of the monthly risk assurance meeting. The leadership team did not always take action to make changes where risks were identified.

Managers and staff did not complete a comprehensive programme of repeated audits to secure assurance of improvements over time. Leaders did not effectively share and make sure staff understood information from the audits and incidents. Maternity service leaders were not always able to provide audit programmes or audit results, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvements. The service reported in the Family Health Quality and Governance meeting minutes in February 2023 that there were 67 audits on a forward plan, 14 were complete, 18 only on going, 27 behind schedule and 5 were abandoned, which included the Saving Babies Lives audit. The service had not completed relevant clinical audits including the national perinatal mortality audit.

Results from a service modified early obstetric warning score (MEOWS) audit indicated staff did not always carry out clinical observations using MEOWS in a timely way, record the observations, or escalate them appropriately. This meant that there was a risk to women, birthing people and babies coming to harm. The service's MEOWS audit results also indicated that observations were not being taken in line with appropriate frequency, and national and local guidance was not being followed. Significant numbers of MEOWS scores meeting a trigger point should have been escalated. However, this did not occur. Following the recommendations of a HSIB investigation in 2021, the trust had committed to an action plan but, at the time of the inspection, staff had not taken action to ensure MEOWS was used effectively, escalated in line with policy and associated risks were not mitigated.

The trust did not always review or act upon incidents in a timely way. As of 30 March 2023, there were 212 incident cases remaining open for over 60 days, including incidents from as far back as October 2021 that continued to await review or closure. Delays in the trust completing incident reporting would not give the trust or its staff the opportunity to learn lessons or implement change. The trust had recorded its highest numbers of incidents remaining open in November 2022 at 216 and this had remained at over 190 on 1 February 2023. There was a significant lack of evidence of learning relating to the Healthcare Safety Investigation Branch (HSIB) and perinatal mortality review tool (PMRT) action plans completed from cases from 2019, 2020, 2021 and 2022.

We reviewed the trust's HSIB cases aggregate report presented to the board in March 2023. Recurrent identified themes included lack of MEOWS escalation, policies not being followed, lack of review and oversight of governance, lack of promotion of learning, and issues around the trust's safety culture. Although the reports marked the actions had been completed, the trust provided no evidence of actions taken, embedded, or shared.

Maternity

Investigation reports from HSIB stated outcomes for women, birthing people, and babies may have been negatively impacted as a result of the lack of risk assessments, lack of learning from incidents, and lack of embedding national immediate essential actions. Senior staff provided assurance to the board that actions identified by HSIB had, or would be completed. However, information provided by the trust showed these actions remained incomplete. Therefore, inhibiting the ability to improve the service and the experience and outcomes for women, birthing persons, and babies.

The trust had not evidenced working collaboratively to ensure serious incidents were investigated thoroughly. The trust worked with the Local Maternity Neonatal Services, although there was a lack of learning by the trust, a lack of enhanced learning from incidents, and a lack of sharing learning with the LMNS.

Partner agencies had previously reported risks to the trust regarding screening processes and incidents, and for managing results of screening to safely manage care during pregnancies of women and birthing people. Although this was included in the service risk register, screening incidents continued to be identified in some cases throughout all stages of pregnancy and intrapartum care, which provided a lack of assurance and risk process as lessons were not being learnt. The service reported an improving trend had been noted since Quarter 2 for 2022/2023, although some incidents reported as no harm had not been investigated regarding their impact on care. The review process had not been completed and incidents remained open.

The service was reported nationally as being a statistical outlier of babies when born with a low Apgar score in 2022, continuing to the time of the inspection. The Apgar scoring system is a recognised standardised assessment of a newborn baby following birth. This was recognised as being higher (worse) than the national average and in the upper 25% of all organisations with a rate of 29 babies having high scores per 1000 births compared to the national average of 13 babies per 1000 births. The trust staff and leaders did not recognise or have an awareness regarding the service being an outlier with this data. There were no audits or action plans to reduce future risks or improve the outcomes for women, pregnant people, and babies.

The national maternity dashboard showed trust information for the period between March 2022 and February 2023. For 10 months the trust had a higher number of post partum haemorrhages (PPH) than the national average, 1 month where they had the same number, and only 1 month where there were fewer. In April and May 2022 there were 45 in 1000 births, significantly higher (worse) compared to the national average of 29 per 1000.

Midwives told us they were not aware of the service's stillbirth or neonatal death rates, or other key performance indicators, because they not seen the maternity dashboard.

The trust did not always use perinatal mortality review tool (PMRT) appropriately. They did not identify the cause of each baby's death by robustly and comprehensively reviewing each case and the quality of care provided. The service did not work through the care for each baby who died to identify contributory factors where issues were identified and assess whether different care may have made a difference to the outcome (grading of care). The service did not develop and complete action plans that addressed the contributory factors identified, achieve organisational change, or service improvements. The service did not recognise a 'just culture' of accountability for individuals and organisations.

The PMRT was not shared with the trust board regularly. Themes and trends were not identified from these perinatal loss cases. The reports lacked full completion and meaningful action plans, and there was a lack of evidence that actions had been completed. We reviewed some completed PMRTs which lacked relevant information including the baby's birth weight centile. However, 'small for gestational age' was indicated as a theme from the HSIB and the PMRT cases reviewed. Staff reported that they had not had any 'Gap and Grow' training over the last 5 years. 'Gap and Grow' aims to increase the recognition of fetal growth restricted babies and improve outcomes. It includes a benchmarking missed

case audit, where clinicians undertake a 'standardised clinical outcome review and evaluation' (SCORE) of small for gestational age (SGA) deliveries that were not recognised antenatally. Trusts and maternity leads are encouraged to undertake this regularly on a proportion of cases to check for avoidable factors such a failure to follow risk assessments, inaccurate measurement or plotting, or lack of referral for investigation.

Following PMRT case reviews there was no evidence that the trust was providing parents with a robust explanation of why their baby had died, or accepting that in all instances, despite full clinical investigations, it is not always possible to determine this. Staff did not always explain any implications for future pregnancies.

Information Management

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

The service had a lack of processes, and systems for introducing and communicating new or amended trust policies. This meant staff did not have access to up-to-date local or national policies to plan and deliver high quality care according to evidence-based practice and national guidance. Not all policies and guidance were in date or reviewed every 3 years and not all staff could access the policies and guidance.

The service did not always collect and analyse reliable data**.** We requested a copy of the trust's maternity performance dashboard used by senior managers. The service provided a dashboard summary chart which showed key performance indicators and performance over time for some metrics. However, there were no measurable action plans put into place to address key metrics outside of targets. This dashboard showed live performance information which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. Staff told us the maternity dashboard information was not shared with them.

There were errors in the University Hospital of North Durham maternity dashboard data with year-to-date figures being incorrect at times. For example, the maternity dashboard did not contain any data relating to the number of babies with hypoxic-ischaemic encephalopathy (HIE) or numbers of cases referred to Healthcare Safety Inspection Branch (HSIB), or neonatal deaths. The maternity dashboard did not show metrics relating to the service's smoking rates at booking. However, the mandatory maternity data set information identified that these were higher (worse) than the national average. Smoking is a recognised risk factor and the trust had declared partial compliance with Saving Babies lives V2 in March 2022. However, although leaders stated that at the time of the inspection they were compliant, we found there was a lack of risk assessments and audit to assess the adherence to the saving babies lives recommendations.

Staff could not always find the data they needed in easily accessible formats to understand performance, make decisions and improvements. National guidance and local policies were available for staff to access on the trust intranet for those who had access. However, not all Midwives had their own login, so some staff were unable to access information which staff shared.

The PMRT summary report dated from 2022 to 2023 provided by the trust evidenced poor standards in the quality of the PMRT reviews with no external participation. In some reviews only 3 internal staff attended and did not include a member of the senior team. This summary report was not accurately reflected in risk, governance, or trust reports. Throughout both summary reports there was a lack of neonatology involvement.

Maternity

A range of staff from the multidisciplinary team told us they experienced difficulty in accessing the range of information required to provide effective care. This was in part due to the fact that clinical information systems were not always integrated, with EPR systems being relatively newly introduced. However, the trust told us there was an interface between patient record systems.

Engagement

Leaders and staff did not always actively and openly engage with women, birthing people, and staff. There was a lack of collaboration with equality groups, the public and local organisations to plan and manage services.

Leaders did not always work with the local Maternity Voices Partnership (MVP) in decisions about patient care. The MVP said they would have liked more active involvement with the service and stated they were not always included or invited to meetings with the service, which they would have welcomed. This was not a person centred approach to engagement. However, MVP representatives raised concerns with the inspection team about the trust's lack of engagement, in particular with ethnically diverse and vulnerable groups. Since the merge of two previous MVP groups into one, there had been some challenges with working across two sites of the maternity services in this trust.

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

It was not evidenced that the senior leaders understood the needs of the local population outside the continuity of carer programme, despite there being several other communities suffering social deprivation throughout the service's geographical area.

MVP voiced that they had a priority to reach out to the vulnerable and Black Asian and minority ethnic groups. MVP had asked for buy in from the trust and staff since the Ockenden recommendations but at the time of discussions the trust had not taken up this offer, and the MVP would continue to pursue this going forward.

MVP advised that the Continuity of Carer programmes targeted deprived areas. MVP had received feedback that was positive experience of the Continuity of Care model of care being provided. However, they stated the trust did not speak to the women and families from all deprived areas. They felt that the trust did not engage in the MVP meetings, and these were too NHS focused.

MVP stated they had concerns regarding the lack of homebirths as they had recognised that there was an increased number of "freebirths". The trust was not offering home births and the service had been suspended for over a year. The MVP described being frustrated, and women and birthing people had shared they planned to freebirth. MVP described communication re lack of homebirth service had been poor, and women were not being given correct information about being able to attend another provider for their baby's birth.

The Local Maternity Neonatal Service (LMNS) were also involved with the MVP and involved with the maternity engagement group. These groups had identified ways to improve communication throughout the local communities and the top five languages had been shared. Staff told us the trust were engaged with the idea of using different languages. However, at the time of the inspection there was nothing yet in place.

Learning, continuous improvement and innovation

Maternity

All staff were committed to continually learning and improving services. However, staff did not always have the skills and resources to implement improvements to services and these were not always timely or evidenced as being implemented.

Staff were committed to continually learning and improving services. Quality improvement was routinely discussed at trust meetings including action plans such as those following HSIB investigations and PMRT reviews. However, staff had repeatedly reported the lack of acknowledgement of staff ideas and suggestions for improvements.

Leaders stated in reports they would promote change and improvement through training and innovation. However, staff said there had been nothing developed or shared.

The trust had a quality improvement training programme and a quality improvement champion who co-ordinated development of quality improvement initiatives. Staff did not always have an awareness of the trust's quality improvement methods and were not always given the time or skills to use them. The service was not committed to improving services by learning when things went well or there were lessons to be learned and there was a lack of action taken to follow up plans and learning.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support clinical research studies.

Outstanding practice

We found the following outstanding practice:

- Staff showed courage and compassion, and demonstrated real caring for the women, people and babies under their care, whilst demonstrating their own personal resilience. This included staff sharing information with the inspection team on how they would like the maternity service to improve.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The trust must ensure there are sufficient midwives. The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced midwives in order to provide safe care and treatment across the service and reduce delays in provision of safe care to reduce the risk of harm for women, birthing people, and babies. Regulation 18 (1)
- The trust must ensure staff complete all maternity mandatory training including role specific training modules. Regulation 18 (2) (a)

Maternity

- The trust must ensure staff are competent in carrying out CTGs, reviewing and escalating concerns appropriately. Regulation 12 (2) (c)
- The trust must ensure there is sufficient equipment including CTGs to care for women, birthing people, and babies throughout the unit. Regulation 15 (1) (c) (f)
- The trust must ensure staff complete daily checks of emergency equipment. Regulation 15 (1) (e) (2)
- The trust must ensure systems and processes for maternity triage are reviewed so to deliver a safe service in line with national guidance. Regulation 17 (a) (b) (c)
- The trust must ensure clinical observations, screening and testing are carried out in a timely way, reviewed, and escalated appropriately. Regulation 12 (a) (b)
- The trust must ensure completion of risk assessments of women, birthing people, and babies to ensure safe care and improved outcomes throughout pregnancy, delivery, neonatal, and postnatal care. Regulation 12 (a) (b)
- The trust must ensure there are effective governance processes and systems to identify and manage incidents, risk, issues, and performance and to monitor progress through completion of audits, actions and improvements and reduce the recurrence of incidents and harm. Regulation 17 (1) (2) (a) (b) (e) (f)
- The trust must ensure performance audit programmes are carried out, completed appropriately, and reported in line with national standards and guidance. (Regulation 17(2) (a) (b)
- The trust must ensure compliance with recommendations and reviews are carried out effectively to ensure actions and changes in practice are completed and performance is reported correctly. 17(2) (e) (f)
- The trust must ensure engagement with women, birthing people, and families to listen and involve them in investigations and reviews, and to include all local communities and groups. Regulation 17 (2) (e)
- The trust must ensure Duty of Candour is carried out appropriately. (Regulation 20).

Action the trust SHOULD take to improve:

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- The trust should continue to ensure all staff complete multidisciplinary skills and drills training.
- The Trust should continue to ensure there is sufficient and accessible emergency resuscitation equipment to care for women, birthing people, and babies throughout the maternity unit.
- The trust should ensure that there are appropriate facilities for use by bereaved families to meet national standards and guidance.
- The trust should ensure effective measurement of acuity in all areas to enable appropriate and sufficient staffing to provide safe care.
- The trust should ensure staff are encouraged and supported to report staffing problems and act upon them appropriately. Regulation 18 (1)
- The trust should ensure leaders are visible, approachable, acknowledge and manage the issues throughout the service.
- The trust should ensure a just and safe culture to support staff in their work and strive for improvement in the quality and safety of care.

Maternity

- The trust should ensure the vision and values relate to the current model of care and all staff understand and apply them to their work.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.