County Durham and Darlington NHS Foundation Trust

University Hospital North Durham

Inspection report

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Ratings

Overall rating for this location	Good
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?	**Good**

Our findings

Overall summary of services at University Hospital North Durham

Good ↑

The overall summary rating relates to the hospital location rating, which has improved. However, the ratings below relate to maternity services at that location.

Our rating of maternity services at this location **improved**. We rated it as **requires improvement** because:

- The service still did not make sure everyone completed mandatory training and essential skills and drills, although compliance had improved since our last inspection.
- Staff still did not always complete environmental and emergency equipment safety checks, in accordance with trust policy.
- Although there was now a process for documenting arrival times when women and pregnant people attended triage, and formalised, more timely risk assessments were taking place, the new systems in place within the triage unit were not yet fully embedded.
- The service still did not always provide timely inductions of labour to meet clinical need for women, birthing people, and babies. Although data capture and oversight of delays had improved, systems and processes implemented to improve delays were not yet fully embedded.
- The service still did not always have enough senior, experienced midwives on labour wards. Although we found some improvement in terms of numbers of staff and ongoing recruitment, skill mix remained a concern. Systems and processes implemented since our last inspection, to improve staffing were not yet fully embedded.
- Staff did not ensure all medicines and sterile consumable items, were always stored, managed, and replaced timely, prior to expiry dates, in accordance with trust policy and best practice guidance.

However:

- Staff understood how to protect women from abuse. Staff assessed risks to women, acted on them and kept good care records.
- There were now fewer missed opportunities for carrying out screening and for managing results of screening and we saw improved recording and escalation of clinical observations.
- The service now had enough cardiotocograph (CTG) equipment and staff were trained to use it.
- We saw improved incident reporting, timelier actions, and systems were now in place to improve shared learning with staff.
- Maternity service leaders now demonstrated better oversight of audit and identified areas for learning and improvement.
- Leaders and staff had strengthened their engagement with service users, staff, equality groups, and local organisations to plan and manage services.

Maternity

Requires Improvement

University Hospital of North Durham and Darlington memorial Hospital are two of four sites for maternity services for the trust.

Outpatient maternity care, antenatal clinics and community midwifery services are provided at Bishop Auckland and Shotley Bridge Hospitals. However, these were not within scope of this inspection.

There were approximately 4,200 deliveries a year: 2,200 at University Hospitals North Durham (UHND) and 2,000 at Darlington Memorial Hospital (DMH). Water births were suspended at DMH due to water quality issues and these recommenced 01 Jan 2024. The trust home birth service remained suspended, which significantly impacted on service user choice.

The service at UHND comprised of a 13 -bed antenatal / postnatal ward (ward 10), labour ward with 14 labour, delivery, recovery and postnatal (LDRP) rooms, a maternity theatre, induction of labour beds and some enhanced recovery rooms. There was an early pregnancy assessment unit with triage facilities.

We conducted a focused inspection to assess actions taken by the trust following the 29A Warning Notice we served after our last inspection. In addition, we inspected Safe and Well Led key questions within the acute maternity core service. Our inspection was unannounced (staff did not know we were coming).

Is the service safe?

Requires Improvement

Our rating of safe **improved**. We rated it as **requires improvement**.

Mandatory training

The service provided mandatory training in key skills to all staff. Although we saw some improved compliance since our last inspection, the service still did not make sure everyone completed it.

Staff were supported to complete mandatory training and skills and drills training by a practice development midwife (PDM) and a neonatal practice educator. The PDM monitored training compliance. The PDM and line managers monitored mandatory training compliance and alerted staff when they needed to update their training.

Staff were required to complete core mandatory training (trust target 90%), role specific mandatory training (trust target 85%), and service specific mandatory training (trust target 90%).

The service provided multi-professional simulated obstetric emergency training. Staff attended 3 study days a year which included simulated obstetric emergency training and life support training and this time was protected. We requested training compliance data by site. However, the data we received was for combined compliance across both sites. The service reported 95% compliance for midwives, 91% for non-consultant grade doctors and 96% for consultants, against the target of 90%.

We saw some improved compliance. For example, fetal monitoring and surveillance (in the antenatal and intrapartum period), including cardiotocograph (CTG) training now showed 100% compliance for consultants, 98% for midwives and 90% for other medical staff.

However, trust compliance targets for other mandatory training were still not always met.

For example, deteriorating patient and resuscitation training compliance by midwifery staff was 69% and for medical staff, 60% against the trust target of 90%. The action plan we saw indicated the care group and service were to monitor compliance against an agreed trajectory. However, we were unclear how the service was assured staff on each shift were competent.

Hand hygiene training compliance for midwifery staff was 63% and 67% for medical staff, against the trust target of 85%. This meant we were unclear how the service was assured staff were sufficiently trained and always followed best practice regarding hand hygiene.

Infection prevention and control compliance for midwifery staff was 73% and 87% for medical staff against the trust target of 85%. This meant we were unclear how the service was assured midwifery staff were sufficiently trained and always followed best practice regarding infection prevention and control.

Managers did not always give staff time away from clinical duties to complete training and some staff we spoke with told us they could not complete all the training ‘‘because of staffing pressures''. This concurred with information we received from the trust, which showed there were 14 skills and drills completed and 15 planned skills and drills events were cancelled. The October 2023 maternity surveillance report showed overall compliance across both sites for obstetric emergency skills and drills was 83% against the trust target of 90%. The reason given by the service for not meeting the target was ‘’staffing or acuity pressures''.

In addition, staff we spoke with 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 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 received role specific safeguarding training on how to recognise and report abuse. Training records showed 93% of medical staff and 87% of midwifery staff had completed safeguarding level 3 training, against the trust target of 85%.

PREVENT training compliance was 92% for medical staff and 71% for midwifery staff, against the trust target of 85%. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism.

Staff we spoke with gave 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 Act. Staff we spoke with gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

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 all records we reviewed. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the trust safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence 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. Patient records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff we spoke with explained the baby abduction policy. We saw ward areas were secure, and doors were monitored. Staff conducted an abduction drill at both sites in November 2023 and there was an action plan in place to address recommendations.

Cleanliness, infection control and hygiene

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

Most clinical areas we visited were visibly clean and most had suitable furnishings which were clean and well-maintained. However, newly installed seating in the bereavement room had upholstery which was not moisture impermeable. Staff we spoke with were aware of this, however, they were unclear whether the infection prevention and control (IPC) team had completed a risk assessment.

We found staff used incontinence sheets as dust covers, to protect sterile and clean consumables in clinical areas. We discussed this with staff at the time and were told they would now use a theatre towel as a more appropriate dust cover which would be changed following each equipment check.

We saw inconsistent application of green stickers, dated to show when equipment was last cleaned. The most recent cleanliness audit for theatre dated December 2023, gave a rating of 3 out of 5-stars for compliance. and we found dusty high surfaces and equipment, such as visors, in the scrub area. We made staff aware at the time and the equipment was cleaned.

Domestic’s cleaning records we saw were up-to-date and demonstrated that all areas they were responsible for were cleaned regularly.

Water quality of the birthing pool was monitored closely.

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

The IPC team undertook quarterly ‘'back to basics'' audits, which included hand hygiene, across the trust. Results for October and December 2023 showed 100% compliance.

Maternity

Environment and equipment

The service now had enough equipment to ensure safe care and treatment and staff were trained to use it. However, staff did not always complete environmental safety checks and emergency equipment checks. Staff mostly managed clinical waste well.

The service now had enough Dawes Redman specific cardiotocograph (CTG) machines and baby resuscitaire units across labour ward, antenatal ward, pregnancy assessment unit (PAU), and obstetric theatre, to meet Ockenden 2020 report requirements. Most daily resuscitaire checks we reviewed were complete. There was central observation monitoring equipment at the nurses' station as well as computer access to CTGs.

In PAU, there was now an improved area and a nurse call buzzer system put in place for women whilst waiting.

Most restricted access areas were secured with digital locks. The maternity unit itself was secure with a monitored entry and exit system. However, the last baby abduction drill highlighted the risk of potential unauthorised access by tailgating and the service had an action plan in place.

Theatre entrance was via the main corridor in labour ward. There was an external red light which could be switched on manually from inside theatre and notices on the door instructing staff to ensure they locked the door when it was in use, although staff we spoke with told us this was not always achieved. There was no provision to screen women in the event the door was opened accidentally. This meant there was a risk that women's privacy and dignity may not always be maintained.

Staff still did not always complete all environmental safety and all emergency equipment checks in accordance with trust policy, and compliance remained poor. For example, for the period November 2023 to 23 January 2024, the neonatal emergency resuscitation equipment trolley daily check compliance was 54.7%. In addition, we found a bag of intravenous normal saline in the emergency cannulation box had expired, there were several expired blood sampling tubes and the ambubag used during resuscitation, expired in July 2023. Staff we spoke with replaced these immediately.

On the top of the trolley, we saw a supply of slow cooker liners which staff told us they used instead of specially designed clinical plastic bags, to reduce heat loss for neonates. Although UK Resuscitation Council guidance 2021 indicates food quality bags may be used, the service acknowledged that the use of slow cooker bags could impact on the experience of parents, and has ordered alternative supplies.

Checks of labour ward eclampsia equipment, diabetic ketoacidosis (DKA) box, sepsis box and emergency transfer bag were scheduled weekly with the last check recorded 14 January 2024. However, prior to that check, they were not completed for several months. For example, weekly checks for the DKA box were recorded on only 1 day in March, June, and August 2023. There were no records from August 2023 to 14 January 2024. This meant the service could not evidence any checks were completed in September, October, November, and December 2023.

Compliance with daily checks of the adult emergency resuscitation equipment appeared to have improved, with only 8 gaps between October 2023 and January 2024. However, the diary used to record checks was not completed from April 2023 and there was a note which stated, ''diary replaced when lost''. This meant we were unclear how the service was assured these daily checks were completed consistently. In addition, there were no 2024 diaries to record checks from January 2024. Managers we spoke with explained these had been requested but not delivered. However, these were in place when we returned later.

Birthing pool daily safety checks were not completed consistently. For example, for the period July to December 2023, the daily check compliance was 10%. In January 2024, 2 checks were recorded although the pool was used 5 days after the last check. The pool thermometer was recorded as last tested April 2021.

In addition, the policy for use of the birthing pool was due review in 2019. At our last inspection, we were told a pool evacuation drill was planned. However, this was not completed and staff we spoke with were unable to recall when the last pool evacuation drill took place. They told us 5 staff were required on labour ward to undertake a drill and there were not often 5 staff on duty.

There was a dedicated, newly refurbished bereavement room situated adjacent to the neonatal unit. However, the entrance for women and families was gained by walking through labour suite and we were concerned its location may cause some distress to bereaved parents. Staff we spoke with reported the location as being ''women's choice'' as the service had worked with the local maternity and neonatal voices partnership (MNVP) at the planning stage. Following our inspection, the service clarified the location decision was also based on the national maternity survey undertaken in the co-design of the national bereavement care pathways from SANDs. SANDs is a UK charity that works across the country to support anyone affected by the death of a baby.

The mortuary fridge was located on labour ward in a staff office, which also accommodated the staff ''tuck shop''. We were concerned staff may be encouraged to eat and take breaks in the office, which was inappropriate and possible impact on patient dignity and respect. In addition, staff shared concerns that they had to bring a cot into the office to transport babies from the mortuary fridge, through the labour ward to the bereavement room at the end of the ward. We also found daily temperature checks for the mortuary fridge were incomplete. For example, for the period November 2023 to 23rd January 2024, compliance was 25%.

We also had concerns that in theatre, there were latex gauntlets stored next to non-latex gloves. This meant there was a potential risk to patients with latex allergy, and we made staff aware of our concerns at the time.

Most portable electrical equipment was tested and labelled in accordance with the trust's planned preventive maintenance programme. However, some equipment including an infant warmer, a forced air patient warming system, a monitor, computers and resuscitaire temperature gauge had stickers which showed tests were overdue their annual safety test since 2022.

Staff on the wards disposed of clinical waste safely. However, in theatre, we saw overfilled bins containing pharmaceutical waste and one contained a blood bag, which was the incorrect waste stream. We told staff at the time and the bag was removed and disposed of correctly. Sharps waste bins were mostly labelled correctly although those in theatre were overfilled and we saw clinical waste bags contained waste from the previous day's theatre cases, that were not changed.

Assessing and responding to patient risk

Staff now used a triage system, updated risk assessments for each woman and took action to remove or minimise risks. Staff now identified and quickly acted upon women at risk of deterioration. However, the service still did not always provide timely inductions of labour.

Women could access the PAU 24 hours a day. Staff now used the obstetric triage acuity scale (OTAS) tool to triage women and pregnant people on arrival at PAU, although the service recognised the triage process was not yet fully embedded.

For example, the new standard operating procedure (SOP) for triage was due to be reviewed in October 2023 and managers we spoke with explained it was currently being amended. In addition, staff we spoke with did not know where to access specific guidelines to be used in accordance with the SOP, for individual diagnosis of presentations such as such as abdominal pain.

Staff we spoke with explained OTAS was not configured with the electronic patient record, however, managers we spoke with explained the Birmingham Symptom Specific Obstetric Triage System (BSOTS) would eventually be implemented as ''gold standard'' for triage and interface directly with the electronic patient record. This however, required additional staff recruitment.

We observed ward reception staff checked women in on arrival and ensured midwifery staff were aware they were awaiting triage. In addition, there was a dedicated triage telephone line available 24 hours a day, although there was no specific midwife allocated to answer it and staff we spoke with shared concerns that there was a risk calls were missed.However, after our inspection the service provided evidence that managers monitored compliance through frequent audit of calls queued, calls answered, time to answer, call wait times and abandonment rates. The results indicated improvement in managing triage calls.

Women were allocated a triage score and seen in accordance with clinical priority and within waiting times specified by the OTAS tool. Staff documented arrival times when women and pregnant people attended PAU, and formalised, timely risk assessments took place. We observed PAU staff recorded the maternity triage waiting times on a white board.

In addition, junior doctors were deployed in PAU, 9am to 5pm on weekdays to help support PAU teams and enable them to operate the process.

Following our last inspection, the service implemented handheld devices to record clinical observations, using the maternity early warning score (MEOWS) tool in a timelier way, and escalate them appropriately. The devices interfaced with the electronic patient record system in real time and all records we inspected evidenced timely recording of observations and appropriate escalation.

Integrated quality assurance committee minutes we saw reported “escalation of out-of-range observations remains much improved. However, compliance with taking observations at the frequency is below target (although improved) at just over 70%.” Subsequent results provided to CQC in January 2024 showed results range from 82% to 95% for completion of observations and there remained high compliance with escalation requirements.

Daily ward reports were obtained from the EPR system, to monitor compliance and showed a positive increase in the use of the hand-held devices and the system. We saw memos and posters which reminded staff to use the devices.

Staff we spoke with shared concerns that the devices sometimes did not work correctly, although technical support was provided promptly to resolve functional issues and address any individual staff training needs. Staff said they reported any malfunctions on the incident reporting system.

All 7 CTGs we saw were reviewed in line with local trust policy and interpreted correctly. Fresh eyes CTG reviews were mostly carried out at appropriate times during monitoring, in line with local trust policy. All CTGs with concerning features were escalated by midwives according to the trust protocol, and most staff had now received appropriate training in monitoring CTGs. The service audited compliance weekly and data showed improvement in compliance; UHND generally exceed 90%.

Maternity

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 and included delays to inductions of labour.

''Red flag'' data for this metric showed, the service still did not always provide timely inductions of labour to meet clinical need for women, birthing people, and babies, although the trend decreased from July to December 2023. However, the service had developed a 'virtual ward' tool in the EPR system, which was being tested, prior to its implementation. This would enable women waiting at home to be called in to be monitored by the labour ward coordinator and clinical leads, and prioritised appropriately.

We found evidence that reporting, data capture and oversight of delays had improved and no evidence of serious impact on safety. However, new systems and processes implemented to improve delays to induction of labour (such as triage, and actions to address suboptimal midwifery staffing), were not yet fully embedded.

There was now support for the lead screening midwife from 2 band 7 midwives, who provided better oversight, monitoring, and investigation of antenatal and newborn screening incidents. For example, they now captured antenatal and newborn screening incidents from issues with pathology requests. This meant there were now fewer missed opportunities for carrying out screening and for managing results of screening.

National data submitted for the period July to September 2023, showed service performance for timeliness of antenatal screening and newborn hearing screening programme standards were met.

The service routinely audited consultant attendance at complex deliveries in accordance with the Royal College of Obstetricians and Gynaecologists guidance. Audit data we saw for the period June to November 2023 showed the service was compliant with the guidance.

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 EPR syatem.

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

Staff shared key information to keep women and birthing people safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. Staff had 2 safety huddles 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 (SBAR) for each patient.

The service provided transitional care for babies who required additional care. This enabled a mother or parent to stay with their baby together in hospital whilst they, with the team, cared for the baby. It meant the baby was well enough to stay in the postnatal ward, with support from the hospital staff.

Midwifery staffing

The service still did not always have enough maternity staff with the right qualifications, skills, training, and experience to ensure safe care and treatment for women, birthing people, and babies.

Maternity

Although we found some improvement since our last inspection, in terms of management oversight of staffing and ongoing recruitment, it was apparent that the number of midwives and healthcare assistants did not always match the planned numbers, and consistently suboptimal numbers of staff and skill mix remained a concern.

Whilst several new appointments had been made, many of the new staff had not completed their supernumerary period at the time of our inspection and still required significant levels of support and supervision from more experienced midwives. The October 2023 maternity surveillance report to the board indicated supernumerary status of the labour ward coordinator was not always met and averaged 74.6% for the period August to October 2023. However, following our inspection, the service provided additional data for the period November 2023 to February 2024, which showed the supernumerary status achieved at UHND averaged 85.5%.

At the time of our inspection, there were 18 whole time equivalent (WTE) midwife vacancies at UHND.

Active recruitment was ongoing and there was now a recruitment and retention specialist midwife in post. Newly appointed staff we spoke with told us they received a comprehensive induction programme which included supervised preceptorship, competency training and a sufficient supernumerary period. The service recruited additional health care assistants (HCAs) to support midwifery staff. There was an HCA preceptorship programme and new HCAs we spoke with told us they valued the programme and the preceptorship process.

Sickness absence had Increased at UHND and averaged 9.21% between October and December 2023.

Staffing rotas we reviewed showed suboptimal staffing remained a persistent issue. Senior leaders we spoke with concurred that staffing was ''generally always on the low side''. This meant the service could not always provide 1:1 care in labour. For example, the maternity surveillance report to the board for October 2023, showed 1:1 care in labour compliance to be in August 93%, September 98.9% and in October 99%. Staff we spoke with told us delays to induction of labour were ‘a common occurrence’ and we saw 2 such cases at UHND during our inspection. Staff reported these on the electronic incident reporting system.

An escalation process for staffing was now in place, although we were unclear about its effectiveness. Senior leaders we spoke with acknowledged systems and processes were not yet fully embedded. This meant there was a risk of inconsistent decision making regarding whether to implement an external or internal maternity divert, and the service recognised this on its risk register. Managers monitored when women were diverted (when units were closed) and the impact. Data for the period 24 January 2023 to 24 January 2024, showed UHND unit was closed on 33 occasions, with impact recorded as near-miss, no harm or minor harm.

However, we saw the service had taken further action to reduce risk and improve resilience. For example, staffing requirements were evaluated following the service’s Birth Rate Plus report recommendations and new rotas were put in place from November 2023. However, staff we spoke with perceived staffing was ''the same'', ‘'awful'', or ‘'worse'' since our last inspection.

Community Midwives were consulted, and some decided to transfer to the acute setting, which improved midwife numbers. The service also recruited additional HCAs to support staffing shortfalls and ward clerks were available 24 hrs a day to improve support with administrative duties.

There was a dedicated obstetric scrub practitioner for the elective caesarean theatre lists and general scrub practitioners now supported obstetric cases out of hours.

The service also utilised specialist midwives where possible, although some specialist midwives we spoke with shared concerns they did not have sufficient time to complete specialist duties because they were required to work clinically.

Managers now used a recognised acuity tool and accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift. This enabled redeployment of staff within maternity services to be tracked, with the data reported in the maternity surveillance report and to the board. Managers we spoke with told us they worked proactively to achieve 100% fill rate across all shifts and tried to maintain skill balance as much as possible, although this meant staff were sometimes moved. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. They reviewed rosters throughout the day and looked at anticipated activity 7 days in advance.

Staffing was discussed at the daily 10.30am cross-site point in time (PIT) meetings, which we attended on both days of our inspection. However, at one meeting we attended, there was no obstetric representation from UHND. The service clarified this was due to high clinical activity.

Maternity staffing was also discussed at trust-wide daily 7pm command and control meetings, to ensure there was better oversight of maternity staffing risk prior to the night shift. Band 7 ward coordinators reported staffing shortfalls and actions taken to maintain safety, on the electronic incident reporting system. The impact of suboptimal staffing was apparent in the service's 'red flag' data reports. For the period August to October 2023, there were 101, 86 and 71 red flags reported respectively. Senior leaders we spoke with told us they had oversight of these reports and were confident there was no under-reporting.

Since our last inspection, the trust had successfully appointed a Director of Midwifery, due to commence in post from February 2024.

The service's latest Birthrate Plus report, received in August 2023, showed there were 23.40 WTE specialist midwives in substantive funded posts across both sites. However, there were no bereavement or diabetes specialist midwives and the service planned to recruit a band 7 WTE bereavement specialist midwife to cover both sites and 2 band 7 WTE diabetes specialist midwives to cover both sites.

In the interim, a band 7 midwife with time allocated once a month, linked with bereaved families and signposted them to bereavement resources. Three-yearly bereavement training was also provided in accordance with the maternity incentive scheme (MIS), although midwife compliance was only 34% against the trust target of 90%.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, 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 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.

Monday to Friday there was consultant on site cover 8.30am to 10pm incorporating 2 consultant-led rostered ward rounds, as recommended in the Ockenden report. These were incorporated into job plans and compliance was

monitored through signing of handover sheets to confirm presence at the time of handover and compliance was audited monthly. Compliance with signing the handover sheets was variable, which meant the service was unable to demonstrate full compliance with Ockenden immediate essential action 3. However, we saw evidence of follow up with medical staff by the clinical leads, to drive up compliance.

Consultants provided on call cover from home from 10pm to 8.30am. On Saturday and Sunday, a consultant was on site between 8.30am and 2pm and from 8pm to 10pm. Other hours were covered from home. There was a tier 2 doctor (registrar) and a tier 1 doctor (senior house officer) present on the delivery suite 24 hours a day.

There was a dedicated anaesthetist for labour ward 8am to 6pm, Monday to Friday. There was always a registrar level anaesthetist overnight and at weekends to cover maternity and ITU.

The service had low vacancy, turnover and sickness rates for medical staff. For the period March to September 2023, service medical and dental staff sickness rates fluctuated between 2% and 5%.

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.

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

Records

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

Care records were held on a secure electronic system used by all staff involved in the woman's or birthing person's care. Staff kept detailed records of women and birthing people's care and treatment.

Seven healthcare records we reviewed were clear, up to date, stored securely and easily available to all staff providing care.

However, the theatre register was not a bound book and we found loose papers within a ring binder which was used as the theatre register. This meant there was a risk documents could be lost or misfiled. In addition, there were gaps in its completion, particularly recording anaesthetist and scrub practitioner names. Swab and needle checks were not recorded in the register, however, staff we spoke with explained this was recorded in the EPR. After our inspection, the service provided additional evidence which showed swab and needle counts were recorded on the World Health Organisation (WHO) safer surgery sign-out checklists, and then scanned into the EPR.

Each episode of care was recorded by health professionals and was used to share information between care givers.

Medicines

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

Staff did not always follow systems and processes to manage medicines safely. For example, on the ward we found mixed ampoules of injectable emergency medicines used to treat post-partum haemorrhage stored together in a plastic carton and not in original packaging. This meant there was a risk the incorrect medicine could be selected and administered in an emergency. We brought this to the attention of a manager at the time and were told action would be taken to mitigate risk.

Ambient room temperatures where medicines were stored were not monitored, although the storeroom felt very warm. This meant the service was not assured all medicines, for example, intravenous fluids, were stored in accordance with manufacturer's guidance. After our inspection we received assurance the service recognised the potential risk and a risk was added to the service risk register, to consider ways to meet this best practice.

On PAU, we found 5 bags of intravenous fluids which had expired. We brought this to the attention of staff at the time and they were replaced immediately.

The controlled drug registers were completed correctly.

Emergency medicines stored on the bottom of resuscitation equipment trolleys were stored in containers with anti-tamper seals and marked with first expiry dates.

We saw low compliance with monitoring of the medicine storage fridge and freezer temperatures. For example, for the period October to December 2023, ward medicines fridge temperature check compliance was 43%. However, there were no gaps in January 2024 to the date of our inspection.

Women's own medicines were stored securely in individual lockable cabinets. 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. We reviewed 7 prescription charts and found staff had completed them correctly. Medicines recorded on both paper and digital systems were fully completed, accurate and up to date.

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 reviewed.

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 near misses and incidents to report and how to report them in line with trust policy. Managers now reviewed incidents timelier and demonstrated improved compliance with duty of candour. They shared lessons learned with the whole team.

Staff we spoke with described which incidents and near miss events were reportable and how to use the electronic incident reporting system.

Senior leaders we spoke with were confident staff reported all ''red flag'' incidents related to staffing and that staff were clear about what they should report. For example, they reported delayed caesarean sections, and delayed induction of

labour criteria was now clearly defined. Staff we spoke with told us learning from incidents was shared at staff handovers and via emails. However, most staff we spoke with said they did not always have time to check their emails due to staffing. New staff we spoke with told us they were encouraged to attend weekly risk meetings as part of their preceptorship programme. The told us this gave them better insight into incidents and learning from them.

We found improvement regarding management of incidents. For example, we reviewed 4 serious incidents, including reports received from the Maternity and Neonatal Safety Investigation (MNSI) (formerly the healthcare safety investigation branch (HSIB)) since our last inspection and found the service now implemented more robust action plans in response to investigation findings and MNSI recommendations.

Evidence provided by the service showed there were delays in completion of perinatal mortality reporting tool (PMRT) and draft reports. For example, the summary report for quarters 1 and 2 2023-24 showed 60% compliance with completion of a PMRT within 6 months of a baby's death and 60% compliance with completion of a PMRT draft report within 4 months of a baby's death.

The parents' perspective of their care and the care of their baby were included and addressed in the PMRT reports we reviewed. The trust summary report evidenced 95% compliance with this MBRRACE-UK/PMRT standard. Findings were shared with parents in accordance with their wishes.

The service had significantly improved management of open incidents and created a governance and safety matron role to focus on this work. They tracked and reported duty of candour through the quality performance reviews and reports to the care group.

Is the service well-led?

Requires Improvement  

Our rating of well-led **improved**. We rated it as **requires improvement.**

Leadership

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

Leaders understood and managed the priorities and issues the service faced more effectively. We recognised significant improvements made since our last inspection, although new systems and processes were not yet fully embedded.

The trust appointed a Director of Midwifery from February 2024 and ensured leaders maintained high visibility to staff in the service. For example, by walking the department regularly and attending PIT meetings. There were now weekly structured communications to all staff, called ''maternity bitesize''.

Leaders received continued support from the integrated care system, for example, a second Head of Midwifery was seconded to the service for 6 months from February 2024. In addition, the quality team now had an experienced matron who supported maternity services.

Maternity

Staff perception of leadership visibility was variable. For example, some staff we spoke with told us managers were more visible and approachable and that overall, ''things have improved'' since our last inspection, while others told us they were not visible. However, themes identified by the freedom to speak up guardian included a perceived ''lack of visibility of senior leaders across the shop floor''. These themes were shared with senior leaders including those at board level.

Staff we spoke with told us they were supported by their line managers, ward managers and matrons. The service was supported by maternity safety champions and non-executive directors.

Vision and Strategy

The service's vision for what it wanted to achieve and a strategy to turn it into action was not yet fully defined .

Maternity service vision and values were being redefined and needed to be confirmed and communicated once the new Director of Midwifery commenced in February 2024. We were told the new Director of Midwifery had already started engagement with staff informally.

The current focus was on embedding the new triage process as the service prepared to implement BSOTs over the next 12 to 18 months, to allow for changes in pathways and estates work and improved staffing. There was a project team in place to manage this.

Culture

Staff mostly felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff completed mandatory equality, diversity, and human rights training. Compliance was 86% for midwifery staff and 100% for medical staff.

Senior leaders we spoke with told us they were aware of cultural and morale differences between the 2 sites and recognised how this difference impacted on implementation of change since our last inspection.

Leaders had now completed a cultural leadership course and now completed regular check-ins with staff, to listen to their concerns and support them through the change journey. Managers implemented a ''you said, we did'' approach to communicate more widely, management's responses to staff concerns. They told us they intended to monitor effectiveness through a staff survey which was about to be launched.

Staff we spoke with told us they felt more confident to share concerns with more senior staff and knew how to contact the freedom to speak up guardian if required. The freedom to speak up guardian maintained high visibility. Main themes identified by the freedom to speak up guardian were staffing (in terms of capacity and demand to deliver the highest quality care), escalation processes and increasing presence and pressure of supernumerary staff on a shift.

Managers we spoke with told us they perceived morale at UHND to be lower than at DMH. They told us this was due to less experienced staffing and less stable leadership. Staff were therefore not as receptive to managing current challenges and changes.

Most staff we spoke with at UHND told us the morale had ''not improved'' since our last inspection, mostly due to continued suboptimal staffing and poor skill mix.

Maternity

In addition, midwives we spoke with shared anxieties about the service's focus on compliance with using the new handheld devices to record MEOWS. They told us managers held 1:1 conversations with staff who appeared to have missed recording observations in the system. They also received emails from managers, which some felt threatened disciplinary action if they failed to comply with using the devices to record observations when the machines prompted them to. For example, the devices may require staff to complete observations every 15 minutes although a woman's overall clinical picture based upon a midwife's expertise and experience might mean 15- minute intervals were not clinically indicated. They felt this undermined their clinical judgement.

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.

Governance

Leaders had revised strategies and systems in place to improve governance processes, although these were not yet fully embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We saw the service had reviewed and improved its governance processes. Managers we spoke with explained how the revised governance structure anticipated better oversight and more effective identification and management of risk. The service aimed to embed the changes by February 2024 and audit effectiveness by the end of March 2024.

All meetings were to be monthly with the specialty and care group meetings phased to support escalation. The new perinatal governance meeting brought maternity and children and young people specialities together, to focus on maternity and neonatal care. Meetings were now aligned so issues were taken promptly into the core specialties or to care group or into service governance (SAGE) meetings for learning and education.

The perinatal meeting included representation from nursing, midwifery, medical and management, from maternity, neonates, obstetrics and paediatrics, and a corporate patient safety team representative also attended.

Maternity quality and safety, and workforce working groups still met but fed into the specialty, care group meetings and quality committee.

The trust board received governance oversight through the maternity and perinatal surveillance report, which progressed via the maternity safety champions meeting and the integrated quality and assurance committee. The board received maternity safe staffing information in the integrated quality and performance reports, and reporting on serious incidents for maternity was through the Director of Nursing's patient safety and experience report, CQC action plans and MNSI actions.

Maternity and neonatal safety champions meetings were now held 6-weekly and formally minuted. Meeting agenda items included, for example, review of the maternity dashboard and surveillance report, staffing, perinatal mortality review tool report, thematic review of incidents and CQC inspection action plan. Staff were encouraged to attend weekly case-based education and learning sessions, local risk meetings and SAGE meetings to participate in incident reviews and learning.

Clinical governance and clinical audit roles were now reviewed and refreshed. Clinicians presented clinical audit outcomes and leaders were now able to describe audit programmes and audit results. They demonstrated better oversight and identification of areas for learning and improvement.

Maternity

The service provided an updated Ockenden action plan, following an assurance visit from regional maternity and neonatal system colleagues. This showed further actions were required to embed processes and evidence. A quarterly audit cycle was now in place, aligned to the assurance questions to monitor effectiveness. The next assessment of evidence was due at the end of January 2024 with a quarterly report due by mid-February.

The service was compliant with 6 of 10 actions under the maternity incentive scheme (MIS) 2023/2024. This scheme is designed as a financial incentive to support the delivery of safer maternity care. However, the action summary highlighted the service met 91 of 100 criteria elements and had not met 8, (plus 1 which related to information only) from the 10 safety actions. The service had an action plan in place to address non-compliance with PMRT, transitional care, board assurance and midwifery staffing.

Staff were clear about their roles and accountabilities, and now had regular opportunities to meet, discuss and learn from the performance of the service or incidents. For example, actions and lessons learned from the PMRT and MNSI investigation recommendations.

Management of risk, issues, and performance

Leaders and teams used improved systems to manage performance more effectively, although these were not yet fully embedded. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Leaders now had improved clinical risk processes in place which provided better oversight of all risks to patient safety. However, these were not yet fully embedded.

The service's risk register now included clinical risks and risk associated with the requirement to embed processes implemented following our last inspection.

Leaders we spoke with were aware of the most recent national maternity dashboard data for the service. For example, it showed as of October 2023, the rate of babies who were born preterm was higher than the national average and in the upper 25% of all organisations. In the previous 12 months, the rate was similar to the average of all organisations. In response, senior leaders had scrutinised the trust's Saving Babies Lives data and could find no specific care causes. They asserted it may be due to the demographic but would continue to monitor.

At our last inspection, the trust was reported nationally as being a statistical outlier of babies when born with a low APGAR score. The APGAR scoring system is a recognised standardised assessment of a newborn baby following birth. We reviewed the regional dashboard data for October (data source 3 months to May 2023), November (3 months to June 2023) and December (3 months to August 2023) and found the trust was not flagged as an outlier in the region.

We reviewed reports and recommendations by the Maternity and Neonatal Safety Investigation (MNSI) (formerly the healthcare safety investigation branch (HSIB)), from investigations completed since our last inspection and saw evidence to show appropriate actions had now been completed and lessons learnt. For example, the introduction of PIT meetings and a more robust escalation policy to support clinicians, both in and out of hours, to ensure the safety of mothers and babies when the workload was becoming difficult to manage.

The service had a business continuity plan and escalation policy to cope with unexpected events.

Maternity

Information Management

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

The service now collected more reliable data, for example, clinical observations and audit data and used processes, and systems such as direct email, ''maternity bitesize'' structured communications and documented key messages at each handover, for cascading important information to staff. For example, changes to clinical care policies or new policies. Staff we spoke with explained high risk key messages were cascaded for up to a 3-week period to ensure all staff were aware. Handover sheets with these key messages were scanned and retained for reference if required.

Staff had access to local or national policies via the intranet. However, we saw a hard copy waterbirth policy in the pool room which was out of date. This meant there was a risk staff may not refer to the most up to date policy. Following our inspection, the service provided evidence the policy on the intranet was in date.

The service collected and analysed data using the trust's maternity performance dashboard. This 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.

However, the trust's maternity performance dashboard still did not contain any data relating to the number of babies with hypoxic-ischaemic encephalopathy (HIE) or numbers of cases referred to MNSI or neonatal deaths. The maternity dashboard did not show metrics relating to the service's smoking rates at booking, although as of October 2023, the proportion of women who were current smokers at booking appointment were higher than the national average and in the upper 25% of all organisations and has been in the upper 25% for the majority of months since October 2022. Managers were sighted on the service's outlier status.

Clinical information systems were not always integrated. For example, we saw the OTAS triage system was not configured with the electronic patient record. However, we were told this would be resolved with the planned implementation of BSOTs.

Staff completed information governance and data security training. Compliance was 86% for midwifery staff and 93% for medical staff against the trust target of 90%.

Engagement

Leaders and staff had strengthened their engaged with service users, staff, equality groups, and local organisations to plan and manage services.

The service had strengthened its relationship with the local Maternity and Neonatal Voices Partnership (MNVP). They met together bi-monthly, and meetings were minuted. The service's health inequalities midwife worked with the MNVP to map service input against agreed joint initiatives. For example, they worked together to finalise the action plan following the CQC maternity survey. It was evident from November 2023 meeting minutes we reviewed, agreed actions included to develop how, what and when women received information about choice of place of birth. There were also plans to co-produce information in a variety of formats, such as written, film or animation, to increase informed decision making for women and birthing people.

There were plans to explore with another trust, the possibility of co-advertisement of their infant feeding groups on the trust's maternity website, and work with public health, to enable trained breastfeeding peer supporters to volunteer on the postnatal wards.

There was a plan to survey women and their partners on views on ''overnight stays'' for birth partners on the postnatal wards.

Agreed actions were added to a joint action log, to ensure they were revisited at each meeting.

The Local Maternity Neonatal Service (LMNS) was also involved with the MNVP and involved with the maternity engagement group. The service made interpreting services available for women and birthing people and collected data on ethnicity.

The service had improved its compliance with duty of candour. For example, since our last inspection, a full audit of compliance with duty of candour for qualifying incidents was carried out by the patient safety team and gaps were addressed. Evidence, such as correspondence to service users was captured on the electronic incident reporting system and compliance monitored by the patient safety team. The care groups received a monthly report.

Compliance with duty of candour requirements was now reported monthly and flagged through the trust's quality and performance scorecard, with any issues discussed in performance review meetings. Awareness and training materials about the trust's ''being open'' policy were being developed for staff and all staff we spoke with were able to explain what duty of candour meant.

Learning, continuous improvement and innovation

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

Staff were committed to learning and improving services. Quality improvement was routinely discussed at service meetings including action plans such as those following MNSI investigations and PMRT reviews.

The service supported staff to develop their professional roles. For example, 4 midwives were supported to undertake practice development midwife training and 6 fully funded places were secured to provide midwifery training to registered nurses.

The service provided new placement opportunities for student midwives from local universities.

Some staff we spoke with expressed concern that there was no provision in place for structured midwifery supervision and they hoped this may change with the appointment of the new Director of Midwifery.

Areas for improvement

MUSTS

University Hospitals North Durham Maternity

Maternity

- The service must ensure that staff complete all maternity mandatory training, including but not limited to, role specific training modules and skill and drills. **(Regulation 18 (2) (a))**
- The service must ensure staff complete all environmental and emergency equipment safety checks in accordance with trust policy. **Regulation 15 (1) (e) (2))**
- The service must ensure that systems and processes for maternity triage are conducted in accordance with national guidance and embedded, so to deliver a safe service. **(Regulation 17 (2) (a) (b) (c))**
- The service must ensure effective governance processes and systems to identify and manage incidents, risk, issues, and performance, are embedded. Progress must be monitored through completion of audits, actions and improvements and reduce the recurrence of incidents and harm, including, but not limited to, delayed inductions of labour. **(Regulation 17 (1) (2) (a) (b) (e) (f))**
- The service must ensure there are enough 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 service must ensure the proper and safe storage and management of medicines and there is a robust system in place to ensure service users do not receive expired items and expired medicines. **(Regulation 12(2)(g))**

SHOULDS

University Hospitals North Durham Maternity

- The service should consider ways to ensure women's privacy and dignity are always protected when in theatre.
- The service should consider formal risk assessment of safe storage of products containing latex, including but not limited to surgical gloves and gauntlets.
- The service should consider ways to improve security of the theatre register.
- The service should continue to define and develop maternity vision and values and work to embed them into practice.
- The service should consider ways to strengthen data capture within the trust maternity dashboard.

Our inspection team

During our inspection visit, we inspected labour ward, maternity theatre, recovery, antenatal and postnatal wards, and the pregnancy assessment unit.

We spoke with 19 staff, including senior leaders, service leads, matrons, midwives, medical staff, maternity care support workers and student midwives.

We reviewed 7 sets of healthcare records and observed staff providing care and treatment to women.

In addition, we reviewed performance information about the service and information provided to us by the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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