North Cumbria Integrated Care NHS Foundation Trust

Cumberland Infirmary

Inspection report

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Ratings

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

Our findings

Overall summary of services at Cumberland Infirmary

Requires Improvement 

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

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

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

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

We did not review the the rating of the location therefore our rating of this hospital stayed the same, The Cumberland Infirmary is rated requires improvement.

We also inspected 2 other maternity services run by North Cumbria Integrated Care NHS Foundation Trust. Our reports are here:

West Cumberland Hospital – https://www.cqc.org.uk/location/RNNX2

Penrith Community Hospital – https://www.cqc.org.uk/location/RNNBE

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

Good ➔➔

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

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

However:

- Not all staff had training in key skills including life support and safeguarding training.
- Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. The service had made improvements to recruitment and retention of staff.
- Levels of appraisal completion was not in line with trust targets.
- Systems and processes were not in place to monitor competency in the use of medicines.
- The service did not always meet national performance targets for inductions of labour, preterm births over 24 weeks gestation, and massive obstetric haemorrhage of over 1.5 litres.

Is the service safe?

Requires Improvement ➔

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

Mandatory training

The service provided mandatory training in key skills to all staff however, not everyone had completed it.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training was divided into trust core skills mandatory training, maternity specific modules, and multi-professional obstetric simulated emergency training (PROMPT). However, it did not include pool evacuation training.

Maternity

Staff were not always kept up to date with their mandatory training. The trust target for mandatory training was 85% and this target was not met in most staff groups. For medical staff there were 2 training packages with 12 modules in mandatory training and 15 in core skills. Overall compliance with training was 75%. This did not meet the trust target. Medical staff met the target in none of the 12 mandatory training modules and in 5 out of 15 core skills modules.

For midwifery staff there were 2 training packages with 15 modules in mandatory training and 16 in core skills. Overall compliance with training targets was 80%. This did not meet the trust target. Midwifery staff met the target in 8 out 15 mandatory training modules and 9 out of 16 core skills modules.

For non-registered midwifery staff, there were 2 training packages with 9 modules in mandatory training and 14 in core skills. Overall compliance with training targets was 91%. This met the trust target. Non-registered midwifery staff met the target in 7 out of 9 mandatory training modules and 12 out of 15 core skills modules.

Staff had not all completed appropriate advanced life support and neonatal advanced life support training. The trust target was 85% and overall compliance was 82%. Medical staff compliance was 86% which met the target. Nursing and midwifery staff compliance was 76%. This meant that not enough midwifery staff had training to provide lifesaving treatment to women, birthing people and babies in their care. We also found compliance was below the trust target in immediate life support (55%) and newborn life support (56%) training for midwives, and resuscitation training (75%) for medical staff. This was a risk because we were not assured there were enough staff suitably trained to respond to emergency life-saving situations.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. However, not all staff were up to date with training.

The service provided training and competency-based assessments on the use of CTG; a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Midwifery and medical staff compliance was 90%, which met the trust target. Leaders had recognised the delivery of CTG training and assessment online was limited and had plans in place to move this training to face to face delivery.

We found that staff had moving and handling training in place, however we did not see specific pool evacuation training compliance figures. The service provided a list of staff members who had received level 2 patient handling training, but we could not determine if this was all staff who required the training and completion dates ranged from May 2021 to April 2023. This training was not listed as a requirement in the training needs analysis, so we could not determine if enough staff were appropriately trained to evacuate women and birthing people from a birthing pool at all hospital locations.

The service provided infant feeding training to midwives and midwifery support workers in one full, and one half-day sessions, however not all staff had completed it. The service aimed for 80% of staff to complete the training; 35% of staff had completed both the full and half day training. This meant that there was not always enough staff with infant feeding training to provide up to date support to new parents and carers.

Medical staff received regular teaching, both face to face and online. The training was provided most weeks, and covered a range of obstetric and gynaecological topics, including audit outcomes, surgical skills and clinical management of presenting conditions.

Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said managers and specialist midwives prompted them when they needed to renew their training.

The service had a training guideline; it was in date, version controlled and next due for review in December 2025. The guideline included a training needs analysis which outlined all training required to be completed by maternity staff. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standard.

There was a team of specialist midwives across the hospital services. The practice development midwife worked across the two main hospital sites, and the service had recently appointed a health care assistant post on each main hospital site to help develop the training needs, skills and support for healthcare assistant staff, including supporting the new apprentice midwifery posts and career progression for healthcare assistant staff.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse, however they had not all completed safeguarding training.

The service provided staff with training specific for their role on how to recognise and report abuse. We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training.

Not all staff had completed training specific for their role on how to recognise and report abuse. Safeguarding training was provided to staff in line with national intercollegiate guidelines, including level 3 children and adults training for medical and midwifery staff. The trust target for safeguarding training was 85%.

Medical staff overall compliance with level 3 training targets was 69% for safeguarding adults training. This did not meet the trust target. Medical staff overall compliance with safeguarding children's training was 88%, which met the trust target.

Midwifery staff compliance with safeguarding adults training targets was 81%. This did not meet the trust target. Midwifery staff compliance with safeguarding children's training was 91%, which met the trust target.

Support staff and non-registered midwifery staff compliance with training targets met the trust target in both adult and children's safeguarding 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. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people 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 records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Maternity

The service monitored the number of deliveries per month where female genital mutilation (FGM) had been identified. This metric was for information and allowed leaders to monitor prevalence in the locality and respond to any changes.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures. The maternity team shared examples where they worked with external agencies to ensure victims of domestic abuse were supported throughout labour and the post-partum period.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection. Staff told us babies had electronic tags applied following birth and we saw posters in the department, which was in line with the trust's policy.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean. However, we did not see cleaning audits for all areas of maternity services.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff carried out a range of local maternity audits to manage compliance against standards for infection control, cleanliness of equipment and the environment, including UV spray and glow checks completed by domestic supervisors.

The service audited cleaning checks every month. We looked at audits for the last 3 months and found the service received 99% in January, February and March 2023. We saw where there were issues identified, actions were documented, and the area was reaudited to ensure compliance. However, the trust only provided audits for the ward area at the hospital, which meant we did not see evidence of routine cleaning audits in the delivery unit or theatres. We saw areas were clean during the inspection.

The service generally performed well for cleanliness and had effective processes in place to manage cleanliness and infection control. We looked at the most recent infection prevention and control audits from January to March 2023 where overall compliance was 100% in all areas which met the trust target. The audit covered hand hygiene, and personal protective equipment use, as well as cleaning and environmental checks. The audit form gave areas for auditors to identify good practice, learning and concerns, and immediate improvements or actions.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits compliance was 100% for the last 3 months. Additional hand hygiene assurance audits were carried out by the infection prevention team as necessary.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. We saw 'I am clean' stickers were used in all areas during the inspection.

Maternity

Environment and equipment

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

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system, including camera facilities at the entrance to the day assessment unit.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily. Resuscitation trolley checks were carried out daily by each ward team; we looked at records during the inspection and found checks were completed most days. We saw 3 gaps in April 2023 on non-consecutive days.

Staff regularly checked birthing pool cleanliness and records showed they flushed water outlets multiple times each week.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. There were appropriate bereavement facilities located in the maternity department.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there was mood and sensory lighting in the birthing rooms, one room had a birthing pool and pool evacuation net and on the day assessment unit there was a cardiotocograph (CTG) machines and observation monitoring equipment. We saw a small number of isolated equipment issues, for example broken intravenous (IV) fluid stands and a broken lock on a secure room, however these issues were escalated during the inspection, and we saw they were promptly acted on.

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

Ligature point risk assessments had been completed for maternity service and each item of risk was identified, a risk score agreed, and control measures identified. Staff knew about ligature risks in their areas and how to mitigate them.

The trust had a system in place to monitor equipment safety checks which were completed annually. Any faults were documented and escalated or identified as out of commission and removed from the area.

Assessing and responding to risk

Staff did not always complete and update risk assessments. Staff identified and quickly acted upon women and birthing people at risk of deterioration, however risk assessments for new-borns were not always fully completed. Managers were reviewing the triage and day assessment unit pathways and processes, however at the time of the inspection processes in place were not always robust in managing risks to women, birthing people and babies.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Audit results showed that all records checked in March 2023 had been completed appropriately and triggers had been escalated and reviewed in line with guidance. We reviewed 6 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff where appropriate.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. However, processes for staff in triage and the day assessment unit (DAU) to risk assess women and birthing people and respond to those risks were in development at the time of the inspection. We saw draft policies that were in line with national recommendations. The maternity service across both hospital sites was looking at adopting a nationally recognised system which included standardised assessment of women on presentation, followed by clear guidance to help midwives and clinicians determine the clinical urgency in which women need to be seen.

As part of the development work in triage, the service had completed an initial audit of their current practice in February 2023 which showed that on average 80% of women and birthing people were assessed within 15 minutes of arrival, which was slightly below the 90% target. This had improved significantly from the compliance in January 2023 which showed only 20% of women were assessed within 15 minutes of attendance in the department. The average waiting time was 31 minutes in January 2023 which reduced to 12 minutes in February 2023. The service had plans in place to continue to audit compliance when the new triage system was implemented and embedded.

The audit also assessed whether all women attending triage had MEOWS observations undertaken and a target was set at 100%. The audit of the same 5 records reviewed each month showed observations were carried out in 60% of cases in January and 40% in February in triage. It was agreed education was required for all staff around the need for prompt and appropriate use of MEOWS for assessment. The audit was due to be repeated following provision of guidance and education for staff. However, there was no date provided for this at the time of the inspection.

However, waiting times for assessment and medical review in the DAU were not monitored, and managers could not articulate how often women and birthing people waited for long periods of time, or how they were assured it was safe for women to wait for medical review. Staff told us women and birthing people regularly waited over 4 hours, and there was no process in place at the time of the inspection to risk assess this, outside of clinical decision making. The service was working to implement a system to mitigate this risk and support staff to make evidence-based decisions.

Midwives documented telephone triage calls on the electronic patient record using a communication template that guided staff through a structured conversation, providing an individual assessment of each woman and birthing person calling the service. Prioritisation was decided by midwives based on their clinical judgement according to immediate risks and needs of each woman and birthing person; the service was developing a RAG rated risk assessment tool with set timescales for immediate and urgent cases.

The service had small numbers of women and birthing people attending triage and oversight was maintained by the midwifery staff on the ward. Oversight of women and birthing people attending the DAU was maintained through a paper diary of expected attendees and booked appointments.

Maternity

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. The service had audited records to check their compliance with national guidance; 100% of women and birthing people had risk assessments completed at each contact and had a risk level recorded. We reviewed 6 records as part of the inspection and found risk assessments were completed regularly at antenatal appointments and throughout care and treatment that was provided in the acute hospital.

Cardiotocography (CTG) is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes audit(s) for October 2022 to March 2023; the audit was trust wide so we could not determine any differences between hospitals. We found compliance with fresh eyes ranged from 67% in the most recent month to 100% in November 2022 and January 2023. Compliance was RAG rated as green in 2 out of the 6 months we reviewed, amber in 2 months and red in 2 months. We saw in this audit that fetal heart rate was not always auscultated (listened to) before commencing a CTG; this was not in line with best practice. Compliance over the 6 months we looked at averaged 55%, and was RAG rated as red in 5 of the 6 months; most recent compliance was 60% which had improved from the previous 2 months. This meant there was a risk changes in fetal wellbeing could be missed which could affect patient outcomes.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. There are 5 steps in the surgical safety checklist; team safety briefing, sign in, time out, sign out and debriefing. The theatre department audited WHO checklists across surgical services, with the aim of auditing 5 cases per hospital site, per month over 12 months (1200 cases). In 2022-23, 1649 cases were audited. Compliance for 4 out of the 5 steps was at 100%, however for team debrief, compliance averaged 41% across the year, with the lowest compliance at 11% in October to December 2022.

The sample used in the audit was not always evenly spread across the year. Between October 2022 and March 2023, the number of records audited was 89% of the target and 50% of the target between January and March 2023. More records were audited than required in the previous 6 months, so enough cases were reviewed overall in the year, but they were not always spread equally across each quarter.

We observed completion of one surgical safety checklist during the inspection and it was completed correctly.

We saw evidence of good working relationships between staff, including staff being empowered to escalate concerns. The trust identified an incident where midwives had raised concerns during a neonatal life support scenario. Midwifery staff initiated ‘stop the line’ (a campaign to encourage staff to speak up for safety by empowering all staff members to question or seek clarity and, if required, to stop any clinical activity that could cause further harm. This ‘stop’ continues until the safety concern is resolved). Staff escalated concerns to the Lead Midwife, put out a crash call, and called for attendance of a consultant. The baby was successfully resuscitated and transferred to the special care baby unit (SCBU). An internal investigation was completed, and an action plan was agreed to hold weekly resuscitation ‘simulation drills’ on alternating hospital sites for maternity and paediatric staff.

The trust described how staff responded to unexpected medical conditions and emergencies on the maternity unit and we heard examples of good multidisciplinary working with other specialities and in emergency situations. For example, working with cardiology departments both in the hospital and the tertiary hospital to rapidly assess and treat both a cardiac issue and safely deliver a baby.

The service had 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.

Maternity

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Staff were aware of ligature risks in the environment and had plans in place to ensure women and birthing people at higher risk were placed in observable bays.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. 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 had 2 safety huddles a 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 women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

The service completed an audit of handovers in April 2023; 5 electronic patient records were reviewed and 3 out of 5 were documented in line with the trust's process. The 2 handovers that were not documented correctly had been recorded in the incorrect area of the patient record. There was an action plan in place to improve recording of handovers with appropriate timescales and action owners.

Staff did not always complete newborn risk assessments when babies were born. The newborn early warning trigger and track (NEWTT) tool is designed to be used by healthcare professionals working in areas caring for new-borns in the early and ongoing postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NEWTT quarterly. We looked at audits for the last 3 months and found the service met the target in 3 out of 10 indicators; compliance was particularly low in frequency of observations as determined in the care plan (25%) and risk factors clearly identified (58%).

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third party organisations were informed of the discharge.

The service monitored the numbers of babies and women and birthing people readmitted to hospital on their dashboard. We did not see evidence that the reasons for readmission were monitored to identify themes and trends.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers, however there were plans in place to address the shortfalls.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk, however there were enough staff on duty on the day of out inspection to meet the needs of women, birthing people and babies. On the day of inspection midwifery staffing met the planned numbers.

The trust reported maternity 'red flag' staffing incidents across both main hospital locations in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A red flag event is a warning sign that something may be wrong with midwifery staffing. There had been 82 red flag events in the last 6 months; 74% were incidents where the labour ward coordinator was not supernumerary and 24% were delays between admission for induction and beginning the process.

We spoke to managers about how these events were managed, and they had escalation processes in place to dynamically assess staffing and patient acuity and respond to individual incidents. Red flags were incident reported and investigated by managers to check that trust processes were followed, and risk was mitigated appropriately. This issue was identified on the service's risk register and there was an action plan in place to monitor progress in recruitment to address staffing shortfalls.

Managers accurately calculated and reviewed the number and grade of midwives and maternity care assistants needed for each shift in accordance with national guidance. The service last completed a staffing and acuity review in January 2022. It said the service needed 66.52 whole time equivalent (WTE) clinical staff to meet safe staffing levels based on activity at the service. The service had 66.23 WTE clinical staff members, so there was enough staff to meet the planned needs of women, with only 0.29 WTE vacancy. The service had funding for 6.70 WTE specialist and management roles which was 1.28 WTE less than recommended by the assessment. However, the position had changed since the last acuity review. The maternity staffing strategy from September 2022 showed the trust as requiring an additional 1.6 WTE midwifery staff.

We looked at the most recent staffing report sent to the trust's board every 6 months, which reported staffing and absence and planned versus actual staffing in the maternity departments. They showed that staffing in maternity services had ongoing challenges in meeting the supernumerary labour ward coordinator national requirement. The trust had identified recommendations from external incident reviews in February 2022 and increased the staffing budget to uplift midwifery staffing.

The last board report from November 2022 described improved staffing after the increase in establishment, from 30.9 WTE vacancies to 15.5 WTE vacancies. There were recruitment plans in place to fill these vacancies, including recruiting those who were internationally trained, recruiting nurses to work between special care baby unit and maternity, and the trust was recruiting to the new Apprentice Midwifery course in partnership with a local university.

Leaders were aware of the vacancies, and the impact this had on staffing the service across all sites. Overall midwifery staffing was not identified on the maternity service risk register, but leaders in the service told us this was their top risk. The risk of no supernumerary labour ward coordinator was on the risk register and mitigating actions were in place.

There was a coordinator on duty around the clock who had oversight of the staffing, acuity, and capacity and there was always a midwifery manager on call, however the labour ward coordinator was not always supernumerary. There was a daily huddle to review staffing and acuity across maternity services, however DAU did not contribute to this oversight meeting due to the opening hours and the time of the meeting.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was sometimes at short notice.

The number of midwives and healthcare assistants did not always match the planned numbers.

The service had decreasing vacancy rates, turnover rates, and sickness rates and used some bank staff. The trust had reduced the number of WTE vacancies from almost 30 down to 9 WTE vacancies. In addition, they had recruited 2 internationally trained midwives with a further 7 expected in 2023.

Maternity

The service used the NHS Nursing and Midwifery retention self-assessment tool to identify and manage staffing opportunities and improvements. The associated action plan showed the trust had made significant progress for most elements.

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 staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Managers supported staff to develop and there were specialist roles in place. The service had funding for 6.70 WTE specialist and management roles across the trust which was 1.28 WTE less than recommended by the assessment. There were 10 different specialist midwife roles in place in different speciality areas including recruitment and retention, bereavement, infant feeding specialists, perinatal mental health and wellbeing midwives and pre-term birth midwives. Most specialist midwife roles had an allocated role for each site, and the recruitment and retention and digital midwife worked across Cumberland Infirmary and West Cumberland Hospital.

Managers did not always provide support to staff through yearly, constructive appraisals of their work. Average compliance for completing appraisals across all staff groups for, the maternity services in the trust achieved was 65%; this did not meet the trust target of 90%. In the April 2023 board papers, we found that the women and children's care group, which is where maternity services sat in the trusts structure, had the highest compliance with appraisals trust wide, however we saw most staff groups in maternity services across the trust did not achieve this compliance. At Cumberland Infirmary, compliance for midwifery staff was below the trust target at 51% and compliance for non-clinical staff was 0%.

After the inspection, the trust told us there was a delay in electronic reporting of appraisal rates, so each unit maintained its own list of appraisals. In August 2023, average compliance for midwifery staff was 88%, which was slightly below the trust target.

Managers made sure staff received any specialist training and support for their role. There was a newly devised preceptorship package aimed at supporting preceptees in an individualised way; they defined their own learning needs and were supported to complete the necessary mandatory training for the organisation and the maternity service and clinical supervision was included as one of the main pillars of the package.

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. However, appraisal rates did not meet the trust target.

The service had enough medical staff to keep women and birthing people and babies safe.The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. There were 2 vacant medical posts which were being advertised at the time of the inspection. Leaders we spoke with told us there was enough medical staff to provide safe levels of obstetric cover and they were able to meet key targets, including consultant review within 14 hours of admission.

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. We did not see a formalised induction booklet for locum clinicians, but staff we spoke with told us they would be given an orientation to the department and supported by other medical staff on duty.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. Ward rounds were completed twice a day and the service audited compliance to ensure these were happening in line with national recommendations; the most recent audit showed 100% compliance.

Job plans are an annual agreement that set out duties, responsibilities, and objectives for the coming year for medical staff. We reviewed job plans for consultants and saw they were linked to trust and service objectives and consultants were allocated time for teaching, appraisals, and lead roles, such as risk or governance, as well as clinical duties.

The service always had a consultant on call during evenings and weekends. On call consultant duties were clearly set out, including rounds, safety briefings, handovers and in person attendance requirements. However, we saw although this document was circulated to medical staff in October 2020, it did not appear to be a ratified process or policy and it was unclear how staff members would access the document.

Following the inspection, the service confirmed that the roles and responsibilities document was going through the trust's ratification process and due to be finalised and made available to staff following a governance meeting in August 2023.

There were processes in place to support staff to develop, however managers did not always support medical staff to develop through regular, constructive clinical supervision of their work. Overall, the maternity services achieved 65% of appraisals had been completed; this did not meet the trust target of 90%. Compliance for medical staff was below the trust target at 41%. We did not see plans in place to improve appraisal rates in maternity services.

There was a local induction booklet for junior doctors who started their rotation at the hospital. It included key contact details, information about the layout of the service and the makeup of clinical activity and expectations relating to training and meeting attendance.

There was a process in place to sign off middle grade doctors when they were competent in key scenarios. This meant that medical staff were clear when they required a consultant attendance to provide supervision and support, and when they were competent to manage different scenarios. Staff we spoke with told us they were clear when a consultant attendance was required, and that consultant staff could be contacted to provide support in any scenario, where medical and midwifery staff felt it was needed, or where it was required.

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, records audits showed poor compliance in some areas.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used electronic records. We reviewed 6 records and found they were clear and complete. There was evidence of good care planning including women, birthing people and their families.

Maternity

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

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

The service had moved to a new format of records audits and the records audit we saw used the previous methodology. The new tool that the service developed started being used in January 2023 and results were not yet available. We reviewed the most recent audit which was undertaken over a 3-month period from 01 July to 30 September 2022 this was in draft and being ratified during the inspection.

The draft audit report showed 15 records were audited with compliance targets of 95%. Out of 33 criteria checked the service met the target for 16 criteria. Lowest compliance related to documenting initiation of early breast feeding (50%) and evidence a safe sleeping assessment had been completed (64%). The service scored 100% compliance in 16 criteria, including evidence of care planning/evaluation and the summary of labour was complete and accurate.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, however there were no competency checks in place.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 7 prescription charts and found staff had correctly completed them.

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

Staff completed medicines records accurately and kept them up to date. Medicines records were fully completed, clear and up to date. Medicines recorded on digital systems for the 7 sets of records we looked at were fully completed, accurate and up to date.

The service used a paper prescribing system. Midwives could access the full list of midwives' exemptions electronically and they were clear about administering within their remit.

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

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

Staff learned from safety alerts and incidents to improve practice.

The service provided medicines management training to staff, however not all staff had completed it. Compliance for medical staff was 75%, for midwifery staff was 63% and for trust wide specialist midwives was 56%. This did not meet the trust target.

The service had e-learning and competency assessments in place relating to medicine management and calculating drug doses available to midwives and the competency assessments were part of the preceptorship for new midwives. However, we did not receive compliance figures for staff we were not assured training and competency was in line with trust targets.

Incidents

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

Staff knew what incidents to report and how to report them.Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system, and there was clear guidance for them to follow. We reviewed incidents reported from January to March 2023 and found them to be generally reported correctly, however the level of harm reported was not always in line with national guidance. We saw examples where women and birthing people required surgical interventions or had high volume post-partum haemorrhages (PPH) that were reported as low or no harm, but the information indicated the criteria for moderate harm was met.

Incidents were investigated and responded to in a timely way; there were no incidents open over 60 days.

The service had no 'never' events on any wards.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. They shared learning with their staff about never events and incidents that happened elsewhere or occurred jointly with other key areas. Staff and managers reviewed incidents in weekly meetings and incidents. We saw evidence they took a cross-speciality approach to serious incidents and reviewed them with colleagues in paediatrics and theatres, as well as across maternity services at each hospital and the birth centre. We spoke to staff and managers about themes in incidents relating to postpartum haemorrhages (PPH) and they described actions they had taken to address the theme. Staff reviewed every PPH in detail, case by case, to learn lessons and share good practice. They had made improvements to methods and measurements of volume of blood loss. They had a clear understanding of their compliance rates against national targets through the Service's maternity dashboard which showed the target was exceeded in 10 of the previous 12 months.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. We reviewed 3 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. In all investigations, managers shared duty of candour and draft reports with the families for comment. Managers reviewed incidents potentially related to health inequalities; leaders had worked with data analysts in the trust and public health to start identifying health inequalities based on data they held in patient records, like ethnicity, post codes and health concerns and were using this information to improve maternity services accessed in the community.

Staff reported serious incidents clearly and in line with trust policy.

Maternity

In the last 6 months 2 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation and were rejected. One report was returned from an incident reported in May 2022; we reviewed the report and saw there were no safety recommendations. We also looked at the action plans for HSIB reported incidents and saw actions were in place to address both findings and recommendations; they had been regularly monitored and there was clear evidence of completion for all actions.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. We saw duty of candour was considered in incident action plans, ensuring that any learning was addressed, and was evidence of completing duty of candour was recorded in the incident reporting system, which the trust audited. Compliance with duty of candour was monitored through governance meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff discussed serious incidents and shared agreed actions and learning at weekly core maternity meetings and monthly governance meetings. In 2022 and 2023 we saw leaders reminded staff of the importance of completing contemporaneous antenatal records and listening to the fetal heart at all antenatal clinic appointments, which linked to themes we saw in audits and incidents. Managers shared a safety message of the week with staff during safety huddles and handovers and key messages were posted on noticeboards and in bulletins.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Staff produced action plans to address safety recommendations and sharing of learning. Action plans were reviewed at monthly meetings and staff provided evidence in governance meetings and to the board to show compliance with agreed actions. We reviewed 3 completed actions plans from HSIB reports and saw completed actions was evidenced.

There had been 3 neonatal deaths in the last 6 months across the trust. The service reviewed all neonatal deaths by a multidisciplinary group who used the Perinatal Mortality Review Tool. We reviewed 3 sets of perinatal mortality tools, and we saw they had been completed appropriately. We found the reviews were multidisciplinary (MDT), included the views of the parents, and appropriate actions were documented following review. In 2 of the 3 cases, no care issues were found. In 1 case, care issues were addressed, and actions put in place to share learning and improve working relationships with another specialist team.

There were 2 still births across the trust in the last 6 months. The service monitored the still birth rate on a rolling 12-month basis and reported no still births in the last 3 months of reporting.

There was evidence that changes had been made following feedback. Staff explained and gave examples of changing processes to address trends in post-partum haemorrhages.

Managers debriefed and supported staff after any serious incident. During the inspection, we saw a clinical emergency take place and heard about immediate debriefing for staff involved, as well as plans to review the incident.

Is the service well-led?

Good 

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

Maternity

Leadership

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

There was a clearly defined management and leadership structure in place.

The service was led by a triumvirate formed of a clinical director who was a consultant obstetrician, an associate director of midwifery and gynaecology and a senior business support manager for the women and children's care group.

Staff gave examples of joint working between leaders across disciplines within the service, across sites and different specialties within the trust. They also worked with external bodies, agencies and other trusts to ensure care provision for women, birthing people and babies.

The associate director of midwifery was supported by midwife managers and a quality and safety lead midwife, a practice development team, deputy midwife managers, coordinators and specialist lead midwives. The clinical director led a team of obstetrics and gynaecology consultants. A quality and safety manager led quality and safety midwives and further specialists in fetal monitoring and digital systems.

Some management appointments were recent but, leaders and managers worked as a team with a common goal. Roles were clearly defined and embedded.

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

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. The service triumvirate met weekly to discuss and manage service planning and actions. Leaders were honest and open with staff, managers, the board and external stakeholders, giving clear descriptions of achievements, as well as barriers and targets they were working towards. The trust had not achieved all 10 safety actions required for Clinical Negligence Scheme for Trusts (CNST) and their own measures showed they were compliant for 7 out of 10 safety actions. Those that were non-compliant included midwifery staffing, core competency framework training for all staff groups, and antenatal screening and monitoring. The service had provided action plans to work towards compliance for 2024.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis and service leads were based in clinical areas. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were. The trust used an excellence reporting system for staff to nominate colleagues who had shown care and commitment to others, and we saw staff had nominated leaders and managers for their support and making a positive difference during difficult situations.

Maternity

The service was supported by maternity safety champions and non-executive directors. Maternity champions met with the board level maternity safety executive and non-executive director champions monthly. The non-executive director maternity safety champion regularly did ward rounds on the maternity unit to gain feedback and provide opportunities for staff to share information or concerns.

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

Vision and Strategy

The service had a vision in draft format for what it wanted to achieve that was being shared with the local Maternity Voices Partnerships (MVPs), and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision in draft format for what it wanted to achieve. There was a strategy document in place for the current year for maternity services and a 5-year plan was in development. This was in conjunction with the trust's vision and underpinned by its values and behaviours of kindness, respect, ambition and collaboration.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders had consulted with staff and the vision for the service proposed by staff was: "At NCIC, our skilled multi-professional teams are committed to providing high quality, safe and personalised care ensuring shared decision making to maximise the health and wellbeing of all our current and future service users." The proposal had been shared with the MVP for a collaborative approach for a vision to fit staff and service users alike.

Leaders and staff understood and knew how to apply them and monitor progress. Staff could explain the core elements of the vision and strategy and what they meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations. Following the Ockenden review of Shrewsbury and Telford Hospitals maternity service and the Kirkup review of East Kent Hospitals maternity service, the service had developed a 3-year delivery plan. The service had shared the objectives with the Trust wide teams and actions and achievements were recorded.

Culture

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

Staff we met at all levels were friendly and welcoming, professional and helpful. We spoke with staff across all grades and disciplines, and all told us how proud they were to work for the trust, changes that had been made and the service's achievements since the last inspection and more recently.

Maternity

Staff felt respected, supported, and valued**.** We saw, and staff told us, staff from every role were valued and treated as part of a greater team. All staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff survey results for the women and children's care group showed the service was doing well, against trust and national benchmarking scores.

Staff used maternity excellence reports throughout the service to celebrate individual and team experiences of good care and practice and instances of staff working above and beyond their usual duties.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within, and promoted a culture, which placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. We observed an emergency call during the inspection and saw staff consider the safest way to transport the birthing person to theatre whilst maintaining their dignity.

We saw a range of MDT working. There was joint working and communication between specialties and improvements had been made on the transitional care unit. Staff described this as well established and valued the joined up working between paediatrics and maternity. Staff on labour wards reported excellent behaviours and care demonstrated by all staff, from obstetrics, midwifery, anaesthetics, theatres and paediatrics. Following an emergency procedure requiring a full team of staff and clinicians, midwives reported excellent behaviours and care demonstrated by all staff (obstetrics, midwifery, anaesthetics, theatres and paediatrics) throughout. They said "the team really shone during the true emergency… including the support provided, recognition of time, response to call for neonatal resuscitation, and the level of care provided to the baby and support for Mum". Staff reported positively on the quality and thoughtfulness of the debrief held post procedure.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or social disadvantages affected treatment and outcomes which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care.

The service used refugee pathway links with other regions to enable and promote care of women, birthing people, and babies for refugees and refugee communities. Data analysts in the trust had worked with public health colleagues to identify key vulnerable and refugee groups in the area and leaders used this information to help plan service delivery to improve access to these groups, addressing health inequalities in their population.

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

Following on from a patient complaint regarding dietary requirements staff had showed initiative and designed a display board to provide information on the dietary options available. They reported this had benefited both staff and patients.

All staff received training in equality and diversity. The service promoted equality and diversity in daily work and provided opportunities for career development.

Maternity

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was 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 employed 3 freedom to speak up guardians (FTSUG) to support staff who wished to speak up about a concern or issue. Their role was to ensure any issue raised was listened to and feedback provided to staff on any actions taken. There were also 30 trained respect and inclusion ambassadors. A draft copy of the action plan arising from the 2021 staff survey results showed the Women and Children's Care Group were working to improve the experience of staff through their People Promise elements. They had planned to arrange sessions with FTSUG with room bookings across all sites or use virtual drop-in sessions. These were to be in place by September 2022. However, the action plan did not show if these had taken place.

Results from the NHS Staff Survey 2022 for all areas showed scores at the trust were similar to the average scores at comparable trusts.

There was a commitment to safety, and learning and improvement, rather than defensiveness and blame. Staff described the service as a place where it was "fun to learn with a culture to speak about what they don't know without feeling foolish".

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Themes were shared at handovers, huddles, on staff notice boards, governance newsletters, and emails. There had been 4 complaints received in the last 3 months since February 2023 for maternity services across the trust. All had been investigated with 2 investigations completed and 2 in progress.

Staff could give examples of how they used women and birthing people's feedback to improve daily practice.Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

The Women and Children's Care Group Friends and Family test results from July to September 2022 showed 99% of people gave positive responses. The highest scores were for "confidence and trust" and "kindness and respect". However, the lowest score was 91% for "care". The patient experience team had received 22 compliments in the same time period.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Governance processes included all sites. The Penrith birthing centre representation was in partnership and oversight of

the Cumberland Infirmary maternity quality team. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. The trust had developed a clear Quality Governance Framework that included systems and processes in place at and below board level to ensure the delivery of safe, effective, and high quality care, to monitor and improve the standard of maternity services care delivered. This framework worked in conjunction with the Trust Governance Manual and Board Assurance Framework (BAF). Information was presented in service performance reports and reviewed by the trust board and executive team. Specific maternity papers relating to national schemes and reports such as the maternity incentive scheme and Ockenden reports (2020, 2022) were presented to the board. Staff were able to access information to help them form a judgement about the quality of the service.

The Maternity Service Quality, Safety and Safeguarding (QSS) group met online weekly with representation from across the maternity sites. The team reviewed clinical incidents reported in the previous week and monitored ongoing incidents where indicated. The multidisciplinary group promoted and developed a culture of positive management of clinical risk and analysed, evaluated, identified themes and trends, and took appropriate actions. Meetings were minuted and actions were monitored weekly until closed. The group carried out rapid reviews and escalated to the Trust Governance and Patient Safety groups, in line with the Trust Incident Reporting and Serious Incidents policy. They were responsible for ensuring the requirements for Duty of Candour were carried out.

The Maternity Governance Group (MGG) was made up of midwifery and medical leads and met monthly. They carried out incident investigations in collaboration with the clinical director and associate director of nursing for maternity. They met monthly provided oversight of review, monitoring, implementation of governance, and risk management across the maternity services. Lessons learnt were included in safety messages of the week and quality and safeguarding safety bulletins, circulated to all staff in the multidisciplinary team and up to women and children's care group and trust quality teams. They maintained oversight and completion of action plans developed in response to external independent serious incident reports including HSIB and national directives and monitored them until completion and provided assurance reports to the Women and Children's Care Group Board Assurance board.

The lead obstetrician for labour ward chaired the Labour Ward Forum which met monthly to review delivery suite activity, clinical, professional, and organisational information, including the maternity dashboard, trends in reported incidents and feedback from continuous audits to develop and improve clinical aspects of intrapartum care based upon local and national guidance. They ensured compliance with guidelines and all relevant training and had active involvement and participation with the Maternity Voices Partnership. The chair circulated required actions following each meeting.

The Maternity quality improvement and safety committee met monthly to review serious incidents, complaints and risks and themes identified from these. In January 2023 the committee discussed two incidents regarding fetal resuscitation difficulties relating to infection. They shared details of the completed investigations, final reports and action plans with staff and the board.

Staff carried out annual reviews of stillbirths and neonatal deaths and produced a report to share the findings, lessons learnt, and actions taken. A review in 2021 had been carried out in partnership with staff from a local tertiary centre and a subsequent review had been carried out with trust staff only. The service reported external collaboration had been sought, however external reviewers were unable to undertake the work at the time. At each review, cases were examined, and outcomes were discussed. Outcomes at the review stage were the same or very similar to those agreed at the time of each incident.

Maternity

Staff had implemented process changes to improve the team's ability to review notes from cases following a review of stillbirths from 2021. Staff reported reviews, correspondence, and action plans from each incident was now filed on a share drive making it much easier to review and understand the process that had taken place.

A maternity representative attended the monthly trust Delivering Quality and Safety meeting and the Board Quality Improvement Safety Committee where maternity was included within the cycle of business.

The service senior team including the director of midwifery, clinical leads, maternity quality and safety leads and MVP representative attended a monthly Core Maternity Meeting to discuss incidents and risks, reviews and learning. There were also a combined Maternity safety champion meeting and a maternity improvement meeting.

All incident reviews were multi-disciplinary with full involvement and engagement from the obstetric team, Junior doctors were also encouraged to attend as well as midwifery staff, quality & safety leads and colleagues from anaesthetics, paediatrics and medicine.

The service encouraged external reviews and held external peer review sessions using the perinatal mortality review tool (PMRT). Obstetric consultants attended and engaged with the regional clinical network and educational forums including regional clinical groups; Maternity Clinical Advisory Group, Fetal Medicine, Maternal Medicine, Pre-term Birth, Labour Ward Leads, MatNeoSip, Maternity Patient Safety Learning events), LMS and the medical deanery school board. Recommendations from PMRT reviews stated obstetric consultants should also attend case reviews and PMRT meetings as external reviewers for other Trusts.

PMRT reviews had noted a lack of carbon monoxide (CO) monitoring. CO monitoring forms part of the Saving Babies Lives care bundle which aims to reduce stillbirths and had been paused during the Covid-19 pandemic. This had been reinstated by the time of the inspection all women and birthing people were offered CO monitoring at any visit and a compulsory entry had been added to the EPR to ensure this was offered. Records showed monitoring had taken place at booking and antenatal appointments.

The trust complied with their perinatal quality surveillance model through monthly serious incident summary reports and 6 monthly maternity services staffing reports to the trust board, maternity quality dashboard and perinatal review tool reports, and reporting to the local maternity and neonatal system (LMNS) and perinatal mental health network. Trust detection rates of small for gestational age (SGA) babies as reported by the Perinatal Institute for Quarter 4 (January – March 2022) at 48.2% were better than the national average of 41.7%.

Staff produced newsletters and posters sharing learning from incidents. These included summaries of incidents, links to full reports, learning identified, and changes to practice implemented as a result. One incident included information from an external review undertaken to explore further learning. In recognition of the increased postpartum haemorrhage (PPH) rate a change in practice was implemented to ensure prophylactic postnatal syntocinon infusion was offered to all women with high risk factors for PPH.

The service maternity dashboard and perinatal mortality review tool reports were presented to the Quality Improvement Safety Committee and Trust Board in accordance with the requirements of Ockenden and the Maternity Incentive scheme.

The dashboard was collated monthly and discussed at the monthly Maternity Governance meeting in a multidisciplinary forum and at the Care Assurance Board for review by the Care Group. Any actions were progressed through the QSS forum. The service reported PMRT reviews were up to date and undertaken within the prescribed time frames.

Maternity

The Perinatal Mortality Review tool is drawn from data input by the service for every case to the national database. Dashboard data demonstrated the 12 month rolling data for stillbirths showed a small rise from previous months to 0.43%. The national target for stillbirth rate is 0.39%. An examination of data for 2021 had been completed for stillbirths and the first draft circulated for review. Neonatal death data was to be reported after collaboration with the paediatric team. The completed report would be sent to Board for review and for learning would be presented to the LMNS.

The most recent Maternity Serious Incident Summary Monthly Report for March 2023 was presented to the Trust board. Staff described the incident management and review process, with oversight at both Care Group and Trust level. They shared serious incident reports with the trust ICG Serious Incident Closure Panel for assurance.

The service shared Maternity and Neonatal incidents reported as Serious Incidents with the Local Maternity System (LMS) to ensure strengthened multi-disciplinary review and sharing of lessons learnt. The service reviewed and escalated any maternity related incidents reported in line with the Trust Incident and Serious Incident Reporting Policy and Procedures, MBRRACE and HSIB reporting criteria. The service provided the Trust Board with a monthly update on all serious incidents as required by NHSE/I in response to the Ockenden Report 2020 findings and recommendations.

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

The service carried out rapid reviews of all Serious Incidents and reported them to the Director of Governance and the Head of Patient Safety via the Patient Safety Group system. They were then reported to the Trust board and commissioners.

The service provided monthly and quarterly mortality and PMRT reports to the Trust mortality surveillance group (MSG) for oversight. In turn they reported to the Quality Improvement & Safety Committee with links to the Patient Safety Group. The Mortality project group reviewed mortality reviews and reported to MSG.

Maternity Safety and Quality midwives and Quality and Safety Manager worked closely with the ADoM, Clinical Director, the Clinical Governance Lead, and contributed to the Maternity Quality Governance framework. This group held overall accountability for applying the principles of clinical governance to ensure safe delivery of Maternity Services.

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

The service reported that Core maternity meetings were well attended with representatives from all staff groups and specialties. The group discussed perinatal serious incidents including any joint investigation involving paediatrics. They identified themes, planned reviews, and opportunities for sharing learning.

National guidelines for maternity care were reviewed at QSS and highlighted any guidance currently under review. In April 2023 it was identified maternity had 180 current guidelines and had reduced the out of date guidelines from 36 to 3. A thorough process was in place for outstanding guidelines. However, during our inspection we found that although guidelines were up to date, some hyperlinks in electronic records directed the reader to older documents. Staff could

access correct and current references and linked guidance via the internet and intranet. We escalated this to senior staff who offered assurance this would be addressed immediately, and following the inspection, the trust provided evidence that policies had been reviewed, hyperlinks updated, and changes ratified so that staff had the correct links available to them.

Following the inspection, the service also reviewed their system for checking guidelines were up to date to mitigate this happening again in the future.

Management of risk, issues and performance

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

The service had undertaken significant improvement actions to address areas of concern raised at our last inspection with additional monitoring processes and workstreams in place to support and ensure the improvement trajectory was sustained.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings. The maternity dashboard was displayed in staff areas and shared with staff via email.

We reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators, and provided target figures to achieve, where appropriate. There was a system to use the dashboard as a benchmarking tool, and on applicable areas, the service could compare their performance to regional average performance. The dashboard reported on clinical outcomes such as numbers of bookings, deliveries and births, including births in the right place, and maternal clinical indicators (method of delivery, trauma during delivery including postpartum haemorrhage and perineal trauma). It also covered data in regional and national dashboards such as the monitoring of induction of labour. The service’s reports to the board showed the service had benchmarked their compliance rates against other services in the region and had concluded they were not an outlier. Minutes of governance meetings showed the service used local, regional, and national dashboards to measure performance and implemented measures to make and sustain improvements.

The service was meeting national targets in most areas. Although, because overall numbers of deliveries per month were relatively low, the dashboard showed large variations in compliance when actual numbers changed slightly. Some rates showed consistently better compliance than required. For example, incidence of 3rd and 4th degree tears, and smoking rates at booking and delivery.

The service used a RAG (red amber green) rating system to identify when they were meeting or not meeting internally set targets. This meant the dashboard highlighted areas of concern to allow staff to commence improvement work. They were not an outlier regionally and were taking a proactive approach to managing risk and performance. The service did not meet these internally set targets in 8 out of 12 months for the rates of induced labour leading to emergency caesarean, and induced labour of deliveries. The service had not met this target for any of the previous 12 months for

preterm (≤36+6 weeks) birth rate against all births over 24 weeks gestation. To address this, the service had taken action to establish weekly preterm birth clinics at both CIC and WCH with designated Consultants and had recruited 2 preterm birth specialist midwives with regional funding. However, the rolling rate continued to show a steady upward trend over the year.

The service regularly reported performance against national targets to the board and the most recent board papers showed the rate and grading of PPH was discussed. The service had not met the internally set target for 10 out of 12 months for massive obstetric haemorrhage rate. However, they did meet their target for 11 out of 12 months for Postpartum Haemorrhages (PPH) over 2 litres. Senior leaders had expressed concern some cases of PPH had not been considered an SI because of known risks and that this could lead to complacency. The board asked whether the service looked at other issues when assessing criteria for SI, for example site, clinician, or grade of doctor. Leaders explained that they looked at every possible postpartum haemorrhage in detail. It depended on the amount of blood lost, to quantify which needed further investigations but all were discussed by the clinical teams. This was noted and managed within the service's risk system.

The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard and provided an oversight report to the local maternity and neonatal system (LMNS) on a quarterly basis. The oversight report included incident analysis and updates on compliance with national requirements. This meant they could benchmark against other services in the region and contribute to system wide improvements.

The service managers produced action plans following incidents and learning from activities. Action plans were clear and easy to follow, identified all steps and stages required. Individuals or teams were identified as responsible, and timeframes were set. Completed actions were included with evidence of actions taken including letters and emails, changes to guidance and procedures, receipts for equipment as required, instructions for use of equipment, and staff training. Evidence also included completion of duty of candour. All competed actions were noted, dated, and RAG rated green. Managers shared action plans with staff to ensure all those involved and responsible were kept informed. They were also shared with teams for wider learning via email and in safety bulletins.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

Maternity services carried out a quality improvement programme that included approved quality projects, national and local audits, and service evaluations. They participated in national audits including the national maternity and perinatal audit. They monitored clinical audits and recorded progress against risk rating and timeframes through an Annual Cyclical Audit Programme. Audit programme information showed current and completed audits. They shared these with staff, managers, senior leaders, and the board.

The service held weekly and monthly audit meetings. The Maternity Audit Group worked to a set audit strategy and worked with the trust audit team. They reported to the Maternity Governance Group and contributed to the quality agenda by coordinating audit activity for the service to enable compliance with CNST, NHSLA, and CQC standards, and RCOG best clinical practice. They also reviewed recommendations from NICE, Ockenden reviews, National Guidance, audits, and projects relating to departmental practice and initiated audit projects leading from these as well as from incident reviews.

Maternity

The Trust used an electronic risk management system to hold risk registers to enable full oversight of all recorded risks. Individual services and care groups had clear oversight and managed risks relevant to them. They used a risk scoring system to provide a mechanism for risks to be escalated up through the organisation. The Trust Board was responsible for managing strategic risks.

All maternity staff were responsible for the identification of risk and to escalate concerns within their area of work in accordance with the Trust Risk Management policy. The service used a maternity risk register to identify and manage risks. This included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included. Risk owners monitored, updated, and reviewed risks. The Women and Children's Care Group monthly 'Performance Accountability' Framework provided further monitoring of risks. Risk owners updated the register when actions were completed and the senior team closed risks.

The Maternity Quality and Safety team reviewed and managed the Maternity risk register weekly and the Maternity Governance Senior Leadership team reviewed the risk register monthly to discuss and agree actions for top scoring risks.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Clinical audits were carried out using evidence from, and in conjunction with, national requirements and guidance. For example, Saving Babies Lives care bundle Version 2 (2019). Aims were clear, audit tools were ratified and used consistently, and audit findings were RAG rated according to each compliance achieved. Following a review of audit findings, recommendations were made regarding changes to practice and clinical audit improvement plans were produced. These included actions required to meet each recommendation with set timeframes, responsibilities, completion dates and evidence provided to confirm compliance.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. The core maternity meeting minutes showed risks were reviewed at weekly QSS meetings. Risks were RAG rated according to severity and shared with the trust board. Rapid reviews were discussed and actions minuted. Maternity and paediatric staff presented joint reviews where serious incidents involved both departments and resulting action plans were monitored through both Maternity and Paediatric/Child Health QSS forums.

The maternity service risk register provided information on current, open risks and included those identified that had the greatest potential for harm such as lack of a second dedicated obstetric theatre at both sites, and core training that was difficult to access for newly appointed staff such as IV therapy and cannula training. This meant newly qualified Band 5 midwives may not be able to provide all care to women and birthing people as required by their role.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

The trust had an escalation policy for maternity services; it was version controlled and due for review in April 2025. The policy outlined how the service should respond to staffing or acuity issues to ensure safe care of women, birthing people and babies. It was written in line with the escalation procedure that was in place and used at the trust and took into

account looking at the capacity across all 3 maternity units and bed capacity across the footprint, as well as accounting for the system wide approach in the North East and North Cumbria (NENC), to maintain safe service across all trusts in the system. The policy included good practice guidance to reduce system pressures and manage staffing pressures, as well as escalation guidance locally and within regional and national teams, where appropriate.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

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

The service collected reliable data and analysed it**.** The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These were included in a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see data for other services for internal benchmarking and comparison. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice. This allowed the service to benchmark themselves against other NHS acute trusts.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Managers shared and displayed monthly dashboards for staff to access and view service performance.

The information systems were integrated and secure**.**

Data or notifications were consistently submitted to external organisations as required. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK. This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

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

There were systems in place to engage with staff. The senior leadership team told us, and we saw, the wellbeing of all staff was prioritised by senior and local leaders, for example the service had invested in wellbeing midwives.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership (MVP). The service had a well-established relationship with their MVP. Service managers told us Women were best placed to help inform and shape maternity services. Their help and support were sought via a range of forums including user representatives, social media, Maternity IT systems, patient portal, and larger regional engagement via the LMS.

The MVP was very proactive in co-designing maternity services to ensure women's views were represented. They had regular contact with the service and open access to the chief midwife and senior team. They attended formal meetings

with representatives from maternity services, and local women. The MVP worked with maternity services to bridge any gaps with women that could be harder to reach, for example they had completed a survey with local women and birthing people about the development of the maternity website and the MVP and trust had co-produced the development work. The trust valued their partnership working with the MVP and monitored their engagement.

The service worked with external organisations and monitored actions and recommendations from CQC, NHSe, and Healthcare Safety Investigation Branch (HSIB).

There were staff and student information boards in all clinical areas. The student information board included the standards expected of them. There were information boards on corridor walls in all clinical areas. There was a summary of user feedback, comments and actions taken. Details of how to get different types of support, make a complaint and give feedback. Boards also included photographs of staff with their name and role.

The most recent results for the Women's and Children's Care Group Staff Survey were from that carried out in 2021. Staff responses for the service scored better than or equal to all organisational scores for the trust. The service had devised an action plan to make improvements, in particular to responses regarding staff wellbeing and service available learning.

Leaders understood the needs of the local population and the service gathered and shared patient experience feedback. The service made interpreting services for women and birthing people available.

The service held monthly unit meetings to share information on incidents, feedback, patient experiences and risks, new guidelines, updates and new staff introductions.

The service organised an Annual Maternity Services Away Day for all staff in February 2023. Staff discussed inequalities, risk, incidents and outcomes as well as improvements required in communication between maternity and neonatal medical teams. This was a theme recognised from incidents and better methods and process were needed. Neonatal consultants attended to discuss opportunities for making improvements to care.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

The maternity mental health service (MMHS) offered timely access to specialist assessment and evidence-based treatment with a focus on psychological interventions for women having moderate to severe or complex psychological difficulties arising from, or relating to, pregnancy and childbirth, mainly around trauma, loss or fear. The service integrated psychology into maternity care by building upon the Afterthoughts Service and developing strong links with services and working with a range of delivery partners to deliver a co-produced, holistic, personalised and trauma-informed approach to care providing with mental health or psychological input in the perinatal period. This included improving access to psychological therapies (IAPT) or NHS talking therapies.

Maternity

The service received reports of positive communication from midwifery staff who were described as helpful, supportive and well informed. There were positive reports about communications with the wellbeing midwives. The service received positive feedback about consistency and birth planning. Women, birthing people and their partners described the environment as calm and staff had positive attitudes. However, some negative reports were received regarding patient anxiety during transfer of care, busy waiting areas and difficulties experienced by people with neurodiversity needs such as for those living with autism.

The trust provided an excellence reporting system that was used by staff throughout the service to report colleague positive attitudes, actions, and behaviours, often acting above and beyond the expectations of their role. Reports included themes around kindness, compassion, commitment, dedication, professionalism and patience during challenging cases.

Midwives had shown compassion towards socially disadvantaged pregnant people such as asylum seekers who used the service. Staff had advocated for these people and ensured their social and housing needs were adequately met.

The report from the Ockenden assurance visit in July 2022 noted the welcoming environment, openness and honesty amongst multidisciplinary teams and staff who were highly committed to their role with a focus on safety. Amongst the recommendations from this report were the suggestion for the service to celebrate their success and promote it externally.

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

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 service must ensure they assess and do all that is reasonably practicable to mitigate risks to women, birthing people and newborns. Regulation 12(1)(2)(a)(b). This includes but is not limited to:

1. Improve compliance with newborn risk assessments in line with guidance.
2. Improve compliance with debriefs after surgical interventions in line with WHO surgical safety checklist guidelines.
3. Improve compliance in CTG audits in line with best practice and national guidance.
4. Improve performance against national targets for inductions of labour, preterm births over 24 weeks gestation, and massive obstetric haemorrhage of over 1.5 litres.

- The service must have systems and processes in place to ensure the proper and safe management of medicines, including systems to review the training and competency of staff responsible for the management and administration of medication. (Regulation 12 (2) (g)).

Maternity

- The service must ensure enough staff have appropriate life support and resuscitation training. (Regulation 18 (2) (a)).
- The service must ensure staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2) (a)).

Action the trust SHOULD take to improve:

Maternity

- The service should continue to address staffing and recruitment challenges to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed in maternity services.
- The service should continue to improve access to triage and the day assessment unit in the maternity department and monitor and improve waiting times for initial assessment and medical review in line with local processes and national guidance.
- The service should improve access for all staff involved in maternity services to attend multi-professional obstetric simulated emergency training (PROMPT) and develop systems and processes to provide oversight of completion for all staff groups.
- The service should improve compliance with infant feeding training to ensure women and birthing people receive appropriate care.
- The service should review the systems in place to ensure all areas of the maternity department are clean and regularly audited to check compliance with local and national guidelines.
- The service should formalise and ratify the on-call consultant duties documentation to ensure there is clear version control, and the document is accessible to all relevant staff.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors and 3 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.