Royal Devon University Healthcare NHS Foundation Trust

North Devon District Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at North Devon District Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at North Devon District Hospital.

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

North Devon District Hospital provides maternity services to a population of 165,000.

Maternity services include an outpatient department, antenatal and postnatal ward (Bassett), labour ward, and one maternity theatre. Between April 2022 and March 2023, 1,240 babies were born at North Devon District Hospital.

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

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

Our rating of this hospital stayed the same. We rated it as Requires Improvement.

- Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement and well led as Requires Improvement.

We also inspected one other maternity service run by Royal Devon University Healthcare NHS Foundation Trust. Our report is here:

Royal Devon & Exeter Hospital (Wonford) – https://www.cqc.org.uk/location/RH801

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited the Labour ward / Delivery Suite, and the antenatal and postnatal ward.

We spoke with 9 midwives, 2 support workers and 1 woman who was using the service.

We reviewed 12 patient care records, 5 observation and escalation charts and 7 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service. We also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

Our findings

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

Maternity

Requires Improvement  

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

- Staff did not always have access to standardised risk assessment tools for telephone triage or in-person triage. The service relied on individual clinical judgement to remove or minimise risks to women and birthing people. Staff inconsistently complied with processes used to identify and act upon women and birthing people at risk of deterioration.
- Midwifery staffing levels did not always match the planned numbers and tools used to dynamically monitor and adjust staffing levels were not being used effectively by leaders, which put the safety of women, birthing people, and babies at risk.
- Records were not always completed fully in particular Modified Early Warning Scores (MEWS) and incident forms.
- Staff did not always recognise and report incidents. Opportunities to learn from or to take action to improve safety were sometimes missed.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well.
- Regular baby abduction drills were not being carried out by staff.
- The approach to service delivery and improvement was reactive. The audit systems were inconsistent in implementation and impact, which limited effective planning processes and impacted on the management of risks.

However:

- There were enough doctors employed to meet the needs of the service.
- The service managed infection risks well. The environment was suitable, and the service had enough equipment to keep women, birthing people, and babies safe.
- Staff understood the service's vision and values, and how to apply them in their work.
- The service engaged well with women, birthing people, and the community to plan and manage services.
- Women and birthing people could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

Is the service safe?

Requires Improvement  

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Maternity

Staff were required to complete professional obstetric multidisciplinary training (PROMPT) training once a year. The trust target was 90% for PROMPT training, as of October 2023, 86% of junior obstetricians, 89% of consultant obstetricians, and 91% of midwives were compliant with yearly PROMPT training.

Records in October 2023 showed 86% of midwives and 86% obstetricians had completed cardiotocograph (CTG) fetal heart monitoring training against a trust target of 85%. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Cardiotocograph meetings were held regularly with the opportunity for staff to discuss CTGs for learning purposes. Ninety one percent of midwives had completed neonatal life support training.

Staff we spoke with reported that changes to their IT systems had made it difficult to monitor staff training records. Where leaders had identified staff non-compliance, we were told staff were sent reminder emails, so they knew when to renew their training. Managers had access to an electronic reporting system to view staff training compliance. However, we were not assured that systems and processes in place were effective enough to give leaders proper assurance about training compliance.

Staff we spoke with reported they were given limited time away from clinical duties to complete mandatory training, staff were given 3 days per year.

Safeguarding

The trust had not carried out a baby abduction drills to ensure staff responded effectively in the event of an abduction. Most midwifery staff were up to date with training on how to recognise and report abuse, and knew how to care for at-risk women, birthing people, and their families to protect them from harm.

The hospital had not practised what would happen if a baby was abducted within the 12 months before inspection. Staff could not recall when the last baby abduction drill had taken place, and no data was submitted to show one had been recently completed. When asked for further information, the trust told us there was no evidence of a recent baby abduction drill at North Devon District Hospital. While the security of the unit had not been tested, during our inspection we noted ward areas were secure, and doors were monitored.

Staff followed safe procedures for children visiting the ward.

Staff mostly kept up to date with training specific to their role on how to recognise and report abuse. Despite an additional request, compliance for level 3 safeguarding adults was not received for medical staff, which meant the trust could not be assured medical staff had the appropriate skills to safeguard vulnerable adults. However, 96% of midwifery staff had completed safeguarding adults' level 3 against a trust target of 85%. Training records sent to us in December 2023 showed that 83% of midwifery staff and 75% of medical staff had completed Level 3 safeguarding children.

Staff we spoke with could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff could identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Information could be shared through the Child Protection Information System (CPIS). Staff asked women and birthing people about domestic abuse. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff we spoke with could explain 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.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were well-maintained. Wards had recently been refurbished to the latest national standards.

The service generally performed well for cleanliness and staff followed infection control principles including the use of personal protective equipment (PPE).

Leaders completed regular infection prevention and control and hand hygiene audits. We received evidence of hand hygiene audits carried out for July to September, and November 2023 in all maternity areas showing the service compliance with hand hygiene as mostly 100% with only 2 months having episodes of reporting hand hygiene at 90%. However, the service reported a drop in the compliance rate for hand washing before an aseptic task as it was reduced September 2023 to 25%. Data showed cleaning audits were carried out weekly with compliance consistently above 90% for all months.

Staff told us they regularly cleaned equipment after contact with women and birthing people and we found equipment was visibly clean.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment outside maternity theatres was checked daily. From 1 to 29 November 2023, adult resuscitation trolleys checklist audits showed staff checked the equipment at every shift, although there were 2 days when this had not been completed.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The design of the environment followed national guidance. Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called. The maternity unit was fully secure with a monitored entry and exit system.

The service had enough suitable equipment to help them to safely care for women, birthing people, and babies. For example, in the birth centre there were pool evacuation nets available in both birthing pool rooms, and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

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.

Maternity

Assessing and responding to risk

Staff did not always have access to standardised risk assessment tools, and the service relied on staff clinical judgement in order to remove or minimise risks to women and birthing people. Staff inconsistently complied with processes used to identify and quickly act upon women and birthing people at risk of deterioration, this included electronic fetal monitoring during labour.

There was no formal risk assessment tool for maternity triage. The service relied on staff clinical experience to risk assess women and birthing people over the phone and on arrival. This meant there was a risk where opportunities to prevent or minimise harm could be missed. The service did not ensure women and birthing people were prioritised and seen in a timely manner according to clinical need.

There was no dedicated call handling system or answerphone message for women and birthing people attempting to access triage by telephone. The trust did not actively monitor call drop off rates, where women and birthing people called without getting through. Women and birthing people were required to contact labour ward or antenatal ward if they needed assistance, with a reliance on staff working in those areas to handle the calls in addition to their other job requirements; this meant a risk of delays accessing vital information or advice in the event of an emergency. We escalated this to the trust after the inspection and asked them to provide us with assurance that triage provision was safe. Following this, the trust diverted phone calls to a mobile phone carried by a registered midwife to reduce the risk of calls being missed. The trust provided an action plan to set up one dedicated triage phone number for the Royal Devon University Healthcare NHS Foundation Trust where calls could be handled by a dedicated triage midwife.

Leaders and staff did not monitor waiting times to make sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Arrival times for both midwifery and medical reviews were not easily accessible to staff, which increased the risk that women and birthing people were not assessed in a safe and timely manner. Patient notes did not clearly show if women and birthing people had been seen by a midwife or a doctor. Following the inspection, the trust shared plans to optimise the electronic patient records system and install a digital triage whiteboard to ensure better oversight of patient journey and women and birthing people could receive treatment within agreed timeframes.

Staff did not always escalate concerns when there were signs that the condition of women and birthing people could be deteriorating. Staff used a nationally recognised Modified Early Warning Score (MEWS) tool to identify women and birthing people at risk of deterioration and direct staff when escalation may be appropriate. The trust had completed a recent audit between August and October 2023 of 10 records to check they were fully completed and escalated appropriately. The audit looked at maternity records from this hospital and maternity services at North Devon District Hospital. The audit showed 50% of MEWS charts were completed and that 50% of women with abnormal scores had been escalated correctly. This meant the service could not be assured all women at risk of deterioration were escalated appropriately. However, during the inspection we reviewed 5 MEWS records and found evidence staff had completed 4 MEWS records escalating concerns to senior staff where appropriate.

The audit also found that 4 out of 10 Newborn Early Warning Trigger and Track (NEWTTs) charts were completed fully, 5 babies who had abnormal NEWTT scores were escalated appropriately. Staff used the fresh eyes approach to carry out fetal monitoring. Following additional information requests the trust provided a recent review as well as a historical audit completed in 2021. The recent document audit showed 3 of 10 cases had received hourly fresh eyes. The results

suggested staff were not following best practice. Therefore, the trust could not be assured fresh eyes were completed regularly or were being completed by staff in accordance with Saving Babies Lives version 3, July 2023, element 4 "effective fetal monitoring during labour". Ineffective and inconsistent monitoring processes increased the risk of delays to treatment and may result in serious harm to women, birthing people, and their babies.

The trust had a programme of repeated audits to check surgical safety compliance. Surgical safety WHO theatre checklist audits showed consistent non-compliance with step 1 where staff were required to complete a sign in step to ensure all preparations have been made for the surgery and that it was safe to give anaesthesia. The average compliance from months September to November 2023 was 73%. This may not be enough to ensure the service is safe.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

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

Shift changes and handovers included all necessary key information to keep women, birthing people, and babies safe. The trust completed 2 safety huddles each shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information. Staff used a Situation, Background, Assessment, and Recommendation tool (SBAR) to handover care. SBAR audits completed by the trust between September and November 2023 showed 10 sets of random notes were reviewed per month; overall 100% of cases had a situation, background and recommendation section completed and 93% had the assessment section completed.

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

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

Midwifery Staffing

Staffing levels did not always match the planned numbers; tools to adjust staffing levels in response to pressures were not being used effectively by leaders putting safety at risk. Staff were not supported in their work with annual appraisals.

The service reported maternity 'red flag' staffing incidents in line with the National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. The service did not actively monitor and report red flags involving ward coordinators' supernumerary status in line with the maternity incentive scheme 2022 safety action 5. On the day of inspection, we saw the coordinator was not supernumerary and was working clinically throughout the day, which impacted their ability to monitor and respond to staffing pressures, acuity, and capacity.

Inconsistencies were identified in the reporting ofred flags and use of staffing acuity tools. Between November 2022 and November 2023, the trust reported 11 red flag incidents. Separate data was provided which identified 513 red flag

incidents over the 12 months until December 2023. Of these incidents 504 were reported as delays in continuation of induction of labour, which may indicate there were not enough staff to manage inductions of labour safely. Following a request for further assurance the service implemented a risk assessment tool used to aid the prioritisation of women and birthing people requiring inductions.

The National Reporting and Learning System (NRLS) data for the service did not specify time delay for perineal repair, meaning it was not clear how long women had to wait before receiving care. The impact of this was the service was not fully assured repairs were done in a timely way. Waiting longer than 60 minutes for perineal repair was nationally recommended as a reportable 'red flag' incident. Between dates 12 December 2022 and 11 March 2023 we identified 5 out of 301 trust wide incidents where women required suturing following a 3rd or 4th degree tear during a vaginal delivery, but no times were given to indicate if there was a delay due to staffing availability.

Managers did not consistently support midwifery staff to develop through regular, constructive clinical appraisal of their work and evidence provided on 29 November 2023 showed 203 out of 387 (52%) of midwifery staff across both maternity locations had received their appraisal.

Managers regularly reviewed the number and grade of midwives, midwifery assistance needed for each shift in accordance with national guidance. They completed a maternity safe-staffing workforce review in line with national guidance in January 2021. This review recommended 70.3 whole-time equivalent (WTE) midwives compared to the funded staffing of 67.7 WTE, a shortfall of 2.6 WTE staff.

The Annual Staffing Review Maternity 2023 reported 6.5% absence rate for midwives in September. Budgets for staffing showed a deficit of 0.3 WTE variance for registered midwifery staff and a deficit 2 WTE for midwifery care assistants.

Staff were required to regularly update a staffing tool used to dynamically risk assess staffing to ensure there was a safe staffing establishment and skill mix allocation. However, during the inspection, managers were not consistently updating this due to high levels of staffing pressure, which meant opportunities to reallocate staffing could have been missed.

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

Medical staffing

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

The service had access to medical staff with a variety of skills and availability. There were enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy rate of 1.3 WTE vacant full-time consultants and was 4.3 WTE over budget full-time middle-grade doctors.

Managers could access locums when they needed and made sure locums had a full induction to the service before they started work. Some locum cover was required to support with the resident on-call rota. Locums on duty during the inspection told us they were well supported and confirmed how they received a comprehensive induction.

Maternity

Doctors carried out a twice daily ward round. The service always had a consultant on call during evenings and weekends. However, some staff told us it was sometimes difficult to have women and birthing people reviewed in triage in a timely manner if doctors were deployed for other activities.

Managers told us medical staff were supported to develop through regular, constructive clinical supervision of their work, however evidence provided did not clearly identify how many medical staff had received their appraisal.

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.

Women and birthing people's notes were comprehensive, however some staff noted difficulties switching between inpatient and outpatient versions of the electronic patient records. Staff were able to access both sets of records but some reported feeling more confident than others. The trust used a combination of electronic records. Our inspectors reviewed 5 electronic records whilst on site and found they had all been completed. This contrasted with internal audits completed in June 2023 showing MEWS records had not been completed correctly.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

Controlled drugs were not regularly checked, and medicine used in emergency treatment was not always available increasing the risk of medication errors and delays. Systems to ensure safe management and storage of medicines did not always function as intended.

Staff did not always store or manage all medicines and prescribing documents. Controlled drugs were not always checked regularly in line with trust policy, we found 6 instances at the North Devon District Hospital site between October and November 2023 when daily controlled drug checks had not been recorded. Additionally, we found that medicine required in an emergency was not always easily available, which increased the risks of treatment delays. For example, grab-boxes for emergency treatment of eclampsia were missing medicines to treat it. We escalated this immediately to staff on the day of inspection who rectified it.

Staff provided advice to women and birthing people about their medicines. The service used electronic prescription charts for medicines that needed to be administered during admission. The pharmacy team supported the service and reviewed medicines prescribed.

The clinical room where the medicines and records were stored was locked. Medicines were in-date and stored at the correct temperature at the time of inspection. However, we found 11 instances where fridge temperatures were recorded as outside of the required range over the previous month with limited evidence of action following this variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on digital systems for the 7 sets of records we looked at were fully completed, accurate and up to date.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit. However, during the inspection staff told us they could not always prescribe on the electronic system. During the site inspection we did identify a woman who had been given prescribed medications but there were missed doses of the prescribed medicines without explanation as to why medications had not been administered.

Incidents

Staff did not always recognise and report all incidents. The system and processes for staff to follow were not always completed in a timely manner. There was limited evidence of learning from events or action taken to improve safety.

Not all incidents were reported by staff as there were discrepancies noted in the reporting data. For example, incidents reported did not describe how long women and birthing people had to wait for 3rd and 4th degree perineal repair, removing the trusts' ability to accurately ensure these were reported as red flags where appropriate. A MEWS audit carried out in June 2023 identified only 25% of women and birthing people had been escalated correctly when required. However, no failure to escalate incidents were reported between December 2022 and April 2023. Additionally, actions following this audit identified the need for a new MEWS observation chart to be used by the service, however there was no completion date for this.

We reviewed 15 incidents reported in the 6 months before inspection, but the service had not always made effective changes following these incidents.

We reviewed incidents and found that managers investigated 3 serious incident investigations and found women, birthing people, and their families had been involved in these investigations. It was not clear if managers followed duty of candour in all incidents as this was not stated in the reviews. Data showed the initial 72-hour reviews were not dated or documented clearly, which did not support rapid identification and resolution of gaps in care.

Managers documented the ethnicity of women and birthing individuals involved in incidents as part of the incident review process to assist in identifying events related to health inequalities, where ethnicity may have played a role. However, ethnicity was not explored within the incidents provided by the trust as a possible contributory factor.

There was not always evidence that changes had always been made following feedback. For example, findings from a Health and Safety Investigation Branch (HSIB) report December 2022 recommended the trust made improvements, including the timely assessment for women and birthing people with a risk of rupture of membranes; however, there was no proforma or standardised risk assessment during our inspection, which indicated this recommendation had not been started.

Staff told us they were involved in feedback and learning as part of the incident review process. For example, additional training following a medicines incident.

Incidents were reported by staff and reviewed by leaders who graded them based on severity and harm levels. Any incidents graded above low were then reviewed within 72 hours by the senior leadership team with staff given the opportunity to discuss the incident for learning purposes. Weekly governance meetings were completed to discuss recent incidents and ensured external organisations were notified as required. We found feedback was shared with staff and families and the final reported actions were documented electronically.

Maternity

Trust incident data showed there were 24 incidents open for more than 60 days. These included 6 that were reported in April and May 2023, and 4 were awaiting manager review. Slow incident reviews impacted on timely improvements to care provision, which was a safety risk.

Minutes from perinatal mortality review tool (PMRT) meetings were inconsistent. For example, a review completed in February 2023 did not report any issues however the case did have identified historical complications which may have impacted on the outcome. Additionally, actions were not always documented despite being discussed in the meetings. Further, minutes from August 2023 showed women and birthing peoples' concerns were not always documented, sensitive discussions were completed in the wrong language, and a bereaved mother had not been treated with compassion and kindness. Despite actions being identified as common themes the service had not been included these themes in the actions.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders were visible and supported staff. Leaders had the skills and abilities to run the service, however their ability to accurately understand and managed the priorities and issues the service faced was limited by systems used to monitor service provision.

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. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

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

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.

Leaders had the skills and abilities to run the service, they understood and managed the priorities and issues the service faced. However, leaders' ability to respond to challenges in the service was limited by the lack of oversight and monitoring of the internal systems, in particular triage waiting times and induction of labour processes were not routinely reviewed to ensure women could access care within an appropriate timescale. Following the inspection staff were required to complete an induction of labour delay risk assessment twice a day during the handover process to ensure women and birthing people were prioritised more effectively.

Vision and Strategy

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust had developed the vision and strategy in consultation with staff at all levels in 2023 and covered a 3-year plan. The strategy identified key priorities which included: listening to women and birthing people to provide personalised care, retaining, and supporting staff, culture, and leadership, and improving compliance with national maternity safety initiatives such as the Clinical Negligence Scheme for Trusts (CNST) and the Saving Babies Lives care bundle.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services, plans to revise the vision and strategy to include these recommendations had been made but had not been implemented by 2023 showing a slower than expected response time.

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.

The service had quality improvement projects in progress focused on staff satisfaction and wellbeing. For example, recent culture surveys had been completed by the service to identify and implement improvements in staff culture. Leaders told us they believed staff who were well supported would be able to provide higher quality care to the women and birthing people they worked with.

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 individual 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.

Managers investigated complaints, identified themes, shared feedback with staff and used learning to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used 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 maternity staff survey 2022 reported staff felt involved in deciding changes which affected work and their immediate manager was supportive. The survey also reported staff did not always have access to adequate materials, supplies and equipment required for work. During the inspection we found items were not always available or in date. Ggrab bags used for pre-eclampsia did not contain all the items required to treat the condition and required items from other areas of the hospital. As a response to these, the trust implemented methods to discuss equipment and supply shortages including suggestion boxes and team reviews.

There were quarterly team building and social events, 1-to-1 conversations with managers, and surveys to support staff wellbeing. Staff we spoke with were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and if things went wrong.

Staff we spoke with told us they worked in a fair and inclusive environment. The Workforce Disability Equality Standard (WDES) is a set of measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. For the measure for staff with medical conditions reported more harassment, bullying or abuse, had limited opportunities for career progression and felt pressured to return from a period of sickness before they were ready. This was worse than the national average, however staff with a disability felt their employer had made reasonable adjustments to support them at work which was better than the national average.

Workforce Race Equality Standard (WRES) data collected as part of the NHS Staff Survey results for staff from all other ethnic groups were notably different to results for white staff, indicating poorer experiences for staff from all other ethnic groups. The results showed a higher proportion of staff from all other ethnic groups experienced harassment, bullying or abuse from staff and patients, relatives, or the public in the last 12 months. As well as a higher proportion of staff from ethnic minority groups experiencing discrimination at work within the last 12 months, with a lower proportion of staff believing the organisation provided equal opportunities for career progression.

Results from the CQC Maternity Survey 2023 showed the service scored 'about the same' as other trusts in all areas and 'better than expected' in relation to raising concerns.

Governance

Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service.

Maternity services were part of the clinical support and specialist services division. The service was managed by the divisional director in collaboration with the associate director of midwifery and clinical lead for obstetrics. There was a head of midwifery and a deputy head of midwifery (however this post was vacant at the time of the inspection). The associate director of midwifery reported to the divisional director operationally and professionally to the chief nurse.

Staff did not have access to up-to-date policies reducing their ability to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reported there were 91 of 234 policies out of date at the time of inspection. In response to concerns we raised following the inspection, the trust provided an action plan to review and implement updated policies with a target date of 31 March 2024 starting with those they deemed as high risk.

Leaders regularly held meetings to maintain oversight of the trust and its governance processes. Where applicable the service worked with external partner organisations. Decisions made at meetings were shared with frontline staff via leadership channels. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

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. The service used a variety of methods to share learning with staff including case study discussions during practical obstetric multi-professional training (PrOMPT) sessions, direct feedback, and

support for those involved in serious incidents, information shared through line managers, and updates via internal communications such as email. 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.

Management of risk, issues, and performance

The approach to service delivery and improvement was reactive. The audit was inconsistent in their implementation and impact, which limited effective planning processes and the management of risks. Risk registers and action plans were used, but there was a lack of pace for progress.

The local audit programme was not sufficient to monitor and improve performance over time. The trust had not recognised this risk as part of their maternity services active risk register submitted December 2023. We received limited evidence audits were being regularly completed, and where completed audits were based on insufficient patient sample sizes. For example, triage assessment, CTG monitoring and fresh eyes audits. Staff we spoke with reported that the trust did not complete SBAR or sepsis audits. Following our inspection, the service provided evidence that SBAR audits were completed but did not provide evidence of sepsis audits.

Recent results from audits showed poor staff compliance with guidelines, and no evidence of action taken by leaders to improve. This showed audits were not effective.

The service also participated in relevant national clinical audits. Clinical outcomes were worse than the national average compared with data from National Health Services Digital (NHSD) Maternity Dashboard. Data from August 2023 showed babies with an APGAR score of between 0 and 6 was in the higher than expected with 22 per 1000 births. This was above the national average of 13 per 1,000 births. The number of 3rd or 4th degree tears at delivery was in the upper quartile, with 35 per 1000 births compared to 24 per 1000 births nationally. This metric has been higher than the national average for the past 6 months and had seen a steady increase from 24 per 1000 births in February 2023. The service was aware tears during vaginal delivery were higher than national averages, however, there were no action plans to reduce risk of 3rd or 4th degree tears at delivery at the time of the inspection.

Women and birthing people who were current smokers at booking was 11% which was higher than the national average of 9%. Data collected for current smokers at delivery failed the data quality checks and were therefore not available for August 2023. It was unclear why data had failed, and what the service had done to rectify this.

According to the trusts “Meeting in Public of the Board of Directors of The Royal Devon University Healthcare NHS Foundation Trust 25 January 2023” The trust reviewed the presentation for Clinical Negligence Scheme for Trusts (CNST) and sign-off the evidence presented for compliance for Year 4 (2022). The audit report showed 7 out of 10 actions were compliant. Plans to improve compliance had been implemented and leaders were confident they would achieve higher compliance in 2024.

The service kept a live maternity risk register which identified midwifery and specialist midwives’ vacancy rate, midwifery staff training, and safeguarding provision as their highest risks. These risks were mitigated by a live action plan, actions were signed off once completed. Data shows vacancy rates had improved.

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.

There were plans to cope with unexpected events. They had a detailed local business continuity plan. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

The service collected data to analyse, however key information used to evaluate performance and outcomes was not being collected. The information systems were integrated and secure. Staff could find the data they needed to make decisions.

The service collected data, but key performance indicators were missing from the maternity dashboard, such as ward coordinator being supernumerary as well as other metrics missing described as "reported monthly" making it more difficult to monitor. This was not sufficient to effectively monitor and improve services. The service had a live dashboard of performance which was accessible to senior managers.

The information systems were integrated and secure**.** All IT systems were password protected, and paper-based patient records were stored securely.

Engagement

Leaders collected information on women, birthing people, and staff. They worked with public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

The service had links with the local Maternity and Neonatal Voices Partnership (MNVP). Leaders worked with the MNVP to help make decisions about care in maternity services. The MNVP reported a positive working relationship with the trust but had experienced different levels of engagements between hospitals. In particular, MNVP members told us there was less engagement at North Devon District Hospital compared with the trusts' other locations. Maternity and Neonatal Voices Partnership leaders described difficulties in attending board meetings due to time limitations. A patient experience committee meeting was held quarterly where patient feedback could be discussed with the trust.

Leaders understood the needs of the local population. Where possible the trust had set up outpatient hubs offering additional locations where women and birthing people could attend appointments. Services at these locations included intermittent auscultation where concerns may be identified and referrals for women to attend the local hospital were made.

The service always made available interpreting services for women and birthing people and collected data on ethnicity. Picture books were available to support communication for individuals who may be unable to read translated languages.

Learning, continuous improvement and innovation

Evidence of quality improvement and innovation was limited. However, there was some limited evidence that staff were committed to continually learning and improving services.

The trust was involved in a limited number of improvement projects. In October 2023, the maternity governance group reported the second part of a staff culture survey had been completed with the plan to improve staff culture. Staff had

also completed unconscious bias training in an attempt to address some of the inequalities experienced by people from ethnic minority groups. Training included the use of medical mannequins with darker skin tones. The trust had identified additional areas where services could be improved, work on these areas was in various stages of completion at the time of the inspection.

Leaders had taken the opportunity to discuss issues identified as part of the staff survey to engage with and encouraged staff to find solutions for the identified issues.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure risks are mitigated, including but not limited to ensuring staff have access to an evidence-based standardised risk assessment and prioritisation tool for maternity triage. Regulation 12(2) (a)(b)
- The service must ensure staff comply with systems for the accurate interpretation and escalation of electronic fetal monitoring and is regularly audited. Regulation 12 (2) (a) (b)
- The service must ensure systems are used to effectively monitor and manage women and birthing people requiring an induction of labour, in particular, that checks are carried out within a safe timeframe in line with national guidance. Regulation 12(2) (a)(b)
- The service must ensure staff are compliant with up-to-date safeguarding adults' level 3 training. Regulation (12 (2)(c)
- The service must ensure effective governance and oversight of audits and action plans developed to improve performance. Regulation 17 (1) (2) (a) (b)
- The service must ensure there are effective systems in place to identify, monitor and manage incidents and risks in a timely way. Regulation 17 (2) (a)
- The service must ensure staff have access to up-to-date policies and guidance. Regulation 17 (2) (d)
- The service must ensure labour ward coordinators maintain their supernumerary status in line with the maternity incentive scheme 2022 safety action 5. Regulation 18 (1)

Action the trust SHOULD take to improve:

- The service should ensure the security of the unit is reviewed in line with national guidance. In particular staff's ability to respond to a baby abduction.
- The service should review use of acuity tools to ensure accurate monitoring and response to staffing pressures.
- The service should aim to ensure recommendations made from Ockenden 2020 and 2022 are considered and changes made are made so within a timely manner.

Maternity

- The service should ensure medicines are stored, managed, prescribed, and administered safely.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspector. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care. Additionally, the team comprised of 2 Registered Midwifery advisors and one Obstetric Consultant advisor.