South Tees Hospitals NHS Foundation Trust

The James Cook University Hospital

Inspection report

Marton Road
Middlesbrough
TS4 3BW
Tel: 01642850850
www.southtees.nhs.uk

Date of inspection visit: 21 and 22 August 2023
Date of publication: 19/01/2024

Ratings

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

Our findings

Overall summary of services at The James Cook University Hospital

Good 

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 The James Cook University Hospital.

We inspected the maternity service at The James Cook University 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.

The James Cook University Hospital provides maternity services to the population of Middlesbrough, Redcar and Cleveland and Northallerton.

Maternity services include an early pregnancy unit, maternal and fetal medicine, outpatient department, maternity assessment unit, antenatal ward (ward 19), central delivery suite, midwifery led birthing centre (ward 16, Marton suite), 2 maternity theatres, and a postnatal ward (ward 17). Between April 2021 and March 2022 4630 babies were born at The James Cook University 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.

This location was last inspected under the maternity and gynaecology framework in 2015. Following a consultation process CQC split the assessment of maternity and gynaecology in 2018. As such the historical maternity and gynaecology rating is not comparable to the current maternity inspection and is therefore retired. This means that the resulting rating for Safe and Well-led from this inspection will be the first rating of maternity services for the location. This does not affect the overall Trust level rating.

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

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

We also inspected 1 other maternity service run by South Tees Hospitals NHS Foundation Trust. Our reports are here:

The Friarage Hospital – https://www.cqc.org.uk/location/RTR45

How we carried out the inspection

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

We visited maternity assessment (triage), delivery suite, the midwifery led unit, the antenatal and postnatal wards, obstetric theatres, and the day assessment unit.

Our findings

We spoke with approximately 30 members of the maternity staff at all levels of the service.

We reviewed 6 patient care records, 6 observation and escalation charts and 5 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, recently reported incidents as well as audits and action plans. We then used this information to form our judgements.

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

We rated it as requires improvement because:

- The service was not always able to staff areas to the desired levels. Staffing levels did not always match the planned numbers, putting the safety of women and birthing people and babies at risk.
- There were various aspects of the environment that were not fit for purpose. This had implications for safety, efficiency, privacy and dignity.
- Staff assessed risks to women and birthing people but did not always act on them to remove or minimise risks.
- Leaders did not consistently operate effective governance systems. They did not always manage risk, issues and performance well. They did not consistently monitor the effectiveness of the service, identify and escalate risks and issues and manage these. Though staff wanted to improve services, they did not always have the opportunities and resources to do so.

However:

- Leaders ran services using information systems that were generally reliable, considering the new installation, and supported staff to develop their skills. Staff had training in key skills and worked together for the benefit of women and birthing people.
- The service had a draft vision and values document and was working with staff to gain feedback. Staff understood how to protect women and birthing people from abuse.
- The service generally managed infection risks well and had enough equipment to keep women and birthing people safe.
- Staff were clear about their roles and accountabilities.
- The service engaged with women and birthing people and the community to plan and manage services. Managers generally made sure staff were competent, and staff were focused on the needs of women and birthing people receiving care.

Is the service safe?

Requires Improvement

Mandatory training

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

The mandatory training was detailed and met the needs of women, birthing people and staff. Training included cardiotocograph (CTG) competency (a technique to monitor the fetal heartbeat and contractions), 'skills and drills' training and neonatal life support. Training was up to date and reviewed regularly.

Maternity

Midwifery and maternity support worker staff received and kept up to date with their obstetric mandatory training. Over 91 per cent of midwifery and Maternity Care Assistants (MCAs) had completed all mandatory training courses against a trust target of 90%. Compliance for annual newborn life support training was 91.5% for all midwifery staff (excluding MCAs) across the trust.

The Saving Babies Lives V2 (SBLV2) quarterly data showed compliances of 93% and 96% for January - March 2023 and April - June 2023 respectively for training on fetal monitoring, human factors and situational awareness and successful completion of the annual competency assessment on fetal monitoring. The April 2022 to March 2023 quarterly training compliance figures showed compliance of over 90% with annual CTG training for midwives.

Staff told us they received emails about training which was due. However, staff also said they sometimes had to complete mandatory training in their own time because shifts were often very busy and there was no protected time for this. The trust advised us time was given back for any training done in a staff members own time.

Medical staff received and kept up to date with their obstetric mandatory training. The April 2023 to March 2024 quarterly training compliance figures provided showed compliance of 96% with annual obstetric mandatory training and newborn life support for junior obstetric staff, and 94% with this training for obstetric consultants. The April 2022 to March 2023 quarterly training compliance figures showed compliance of over 90% with annual CTG training for junior obstetric staff, and over 94% for consultants.

Data for combined obstetrics and gynaecology medical staff showed compliance with completion of the 10 generic trust level mandatory training elements ranged from 73% to 100% for each element of training as of July 2023. Data for training compliance from August 2022 to July 2023 for this staff group showed the trust target of 80% was met in only 5 of these months.

Medical and midwifery staff received multi professional simulated obstetric emergency training. We were told obstetric emergency training was multidisciplinary and compliance was 90% for midwives and obstetric doctors. Compliance with obstetric emergencies training for consultant anaesthetists and junior anaesthetists was 90% and 100% respectively. However, staff told us that impromptu ‘skills and drills’ sessions did not happen very often.

Maternity services had a Midwifery Education and Training Group who led on all mandatory training. The group included the clinical educator; fetal monitoring specialist midwife; practice development midwife (PDF); practice development midwife preceptorship lead; midwifery practice placement facilitator; neonatal educators; anaesthetic training leads; obstetric training lead; specialist midwife in public health and specialist midwife in infant feeding.

The clinical educator was responsible for the planning, coordination, implementation and monitoring of the education and training programmes alongside specialist midwives and other members of the multidisciplinary team.

Safeguarding

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

Most staff received training specific for their role on how to recognise and report abuse. The service provided data for compliance with adults and children safeguarding level 3. This showed compliances of 93% for the medical and dental

staff group, and 95% for the nursing and midwifery staff group. In another data source we noted compliance for generic trust level mandatory safeguarding training for the combined obstetrics and gynaecology medical staff was only 73% as of July 2023. Data for midwifery staff was broken down by clinical area. This showed compliance with trust level safeguarding training ranged from 88% to 93% for delivery suite, MAU, ward 17 and 19, being lowest for ward 19 at 88%.

Staff also completed an annual multidisciplinary training day in maternal mental illness. The training focused on teamwork, communication, and the development of skills in acute illness management.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff routinely asked women and birthing people about domestic abuse, female genital mutilation and their mental health. The electronic patient record system had mandatory fields for safeguarding related questions and alerts for people with safeguarding plans in place, which would include a contact and lead consultant. Staff had access to an independent domestic violence advisor for expert advice and support for women, birthing people and staff who might be experiencing domestic abuse.

In triage, records were routinely checked for safeguarding alerts, including on an internal database and on a national system of safeguarding alerts. Staff could see safeguarding concerns from other trusts for unscheduled out of area patients not known to this trust. Staff could contact the safeguarding team to update safeguarding information on the national system.

We saw safeguarding cases in the unit were noted at the morning meeting of midwifery leaders and managers.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The electronic records had a facility which enabled staff to keep necessary documentation confidential. 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. This included a lead practitioner who supported staff if a mental capacity assessment was required and a specialist nurse in learning disabilities.

There was a duty safeguarding nurse every day from Monday to Friday. The service was currently recruiting for a specialist safeguarding midwife due to a vacancy arising. There was a vulnerability lead midwife available to support staff.

The safeguarding team posted regular advice and updates on a closed social media group for maternity staff. They also shared a weekly safeguarding bulletin. This included national safeguarding reports, updated guidance and information and reminders about details for safeguarding training.

Staff told us they used interpreting services for non-English speaking women and birthing people, and information leaflets were available in the most used languages via QR codes. However, we saw that translation services were a repeated theme in incidents.

Staff told us they completed baby abduction drills and we saw the postnatal unit was secure and doors were monitored. Staff told us they had practised what would happen if a baby was abducted within the 12 months before inspection. The last baby abduction drill on postnatal ward took place in April 2023. We were told another drill was due on the day of our inspection but had been postponed until after the site visit.

Maternity

Leaders had worked closely with local charities and secured funding for memory boxes for birth parents and foster carers if a baby was to be placed into the care of the Local Authority. The boxes included early mementoes to start "life story" work and promoted ongoing connection during safeguarding proceedings. This supported the parent(s) through potential grief. No details of the foster carers were to be shared with the birth parents.

Cleanliness, infection control and hygiene

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

All areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Staff cleaned equipment after contact with women and birthing people and it was clear equipment was clean and ready for use.

The service generally performed well for cleanliness. Staff mostly followed infection control principles including the use of Personal Protective Equipment (PPE) which was stored in wall mounted displays. Laminated hand washing posters demonstrating best practice in techniques were on display and we noted all staff were bare below the elbow.

We saw that the Infection Prevention Control (IPC) team completed over 30 hand hygiene audits in maternity for the 3 months prior to our visit. Results ranged from 84% to 98% for the 3 months prior to our inspection.

We saw the results of the latest IPC environmental audit which showed results ranging from 90% to 96% across delivery suite, triage and wards 16, 17 and 19. We were told areas highlighted by the audits for improvement were actioned immediately and assessed at the next audit.

Cleaning audits for May to July 2023 showed results of over 97% and over 98% in all months for ward 19 and ward 17 respectively, and over 99% in all months for delivery suite and the alongside midwifery led unit (MLU, ward 16).

Environment and equipment

The design of premises and facilities was not entirely suitable. The maintenance and use of facilities, premises and equipment, did not always keep people safe. Staff managed clinical waste.

The design of the environment did not always follow national guidance. Data submitted for the inspection acknowledged the maternity service estate affected the ability of staff to care for women and birthing people effectively and according to acuity. Environment issues were on the risk register and the service was consulting an architect about improvements.

We found areas of concern needing urgent improvements. There was no birthing pool on delivery suite or on the Midwifery Led Unit (MLU). Staff used a standard bath instead of a birthing pool, which was unsafe. This was putting staff, women and birthing people at risk because it was not possible to move a bed into the bathroom area or control the water level quickly, nor fit the required number of staff around the bath to assist in an emergency. It was not possible to control water temperature or clean the bath in line with recommendations. This practice was highlighted in a Healthcare Safety Investigation Branch (HSIB) report in August 2023. Leaders were not aware of this practice but responded to our concerns to ensure it stopped with immediate effect.

Maternity

There was no suitable equipment available for use should an emergency evacuation be required when using the standard bath, because the net on delivery suite was not fit for purpose due to wear and tear. The water birth policy did not contain details of an emergency evacuation procedure for water births taking place in the bath. There had not been a drill of the emergency evacuation of the standard bath for women and birthing people using these as pain relief in the first stage of labour (or for water birth against guidance). The trust could not assure itself that staff could safely evacuate people from the bath in an emergency. Following our inspection, the service carried out an emergency evacuation drill for the bath and developed a monthly drill schedule. They also amended the water birth clinical guideline to include details of the emergency evacuation procedure in the unlikely event of a waterbirth taking place in a standard bath. New emergency evacuation kits were now available on the central delivery suite (CDS) and on the Maternity Led Unit, and we were told there was also signage for these in each bathroom on CDS. Leaders also told us training materials had been developed, including an instructional video.

We noted the lack of a water birth pool was stated as a concern in the quarter 4 (March 2023) and quarter 1 (June 2023) provider report to the Local Maternity and Neonatal System (LMNS).

Another area of concern was the security of delivery suite. Entry to the delivery suite was secure via a buzzer; however, exiting was not secure, as pressing a button allowed the doors to open. The service was aware of this risk and was planning to make the exit secure. In the meantime, the exit was close to the reception desk which allowed observation of outgoing people when the desk was staffed. The postnatal ward had a ward clerk Monday to Friday, and staff on the postnatal ward told us they would go to the door to check who was requesting access to the ward. Staff also told us they were planning to introduce a badge system for partners so they could be more easily identified.

There were 12 rooms on delivery suite, 8 of which had “Jack and Jill” bathrooms. This meant that when over half of these 8 rooms were occupied, women and birthing people would need to share bathrooms. Staff told us they would try to minimise the sharing of bathrooms with the arrangement of mobile and non-mobile women and birthing people.

Staff told us it was possible to deliver enhanced care in all rooms on delivery suite and there was a specific room allocated for this too.

There was an induction of labour (IOL) bay on delivery suite. This was a 6 bedded bay with 1 bathroom. There were hard partitions between bed spaces and curtains at the foot of beds, which impacted upon dignity and privacy. The IOL bay was also shared with elective cases attending in the morning, which again impacted upon privacy. To improve privacy for IOLs, staff could offer alternative separate rooms, however these were dated and had no windows. The quarter 4 March 2023 provider report to the LMNS acknowledged the IOL suite compromised privacy and dignity.

There were separate elective and emergency theatres, which reduced the impact of elective cases on emergency cases and vice versa. Staff told us there was good communication about possible emergency cases before starting elective cases, so that if 2 emergencies occurred at the same time, they could use both theatres. We were told there had only been a few occasions where a second emergency had been transferred to main theatres.

Triage had a waiting area, a bay with 2 beds and 3 reclining chairs and 3 individual rooms, one of which could be used for people in labour.

There was a co-located MLU with 7 en-suite rooms; however, it was not always possible to safely staff this, therefore the unit was not always in use. The MLU was physically slightly isolated from the delivery suite and required at least 2

midwives of appropriate skill mix for labourers. If safe staffing levels could not be met, women and birthing people who were low risk and wanted to choose a low dependency environment would need to have this care on the main delivery suite. When in use the MLU emergency buzzers rang in delivery suite. There had been 36 births in the MLU during the period January to October 2023.

The antenatal ward had 8 beds for obstetric patients. They could provide up to 12 beds, depending on patient mix. Other beds were allocated for the Early Pregnancy Assessment Unit.

The postnatal ward had 28 beds, half of which were occupied at the inspection. There was a 10 bedded Transitional Care (TC) unit with 2 bays of 3 beds and 4 side rooms which cared for babies from 34 weeks and a weight of 1.8kg. As a result, babies requiring additional care could stay on the postnatal ward with their mothers rather than go to the Neonatal Unit. TC did not offer nasogastric feeding so babies needing this would need to go to the neonatal unit.

The shower rooms on the postnatal ward were small and dated, and we were told improvements were planned for these.

There was a new sound proofed bereavement suite with a private entrance at the back of the delivery suite. Staff and patients had raised significant funds for the creation of this.

There were concerns about the oversight of equipment. For example, in triage the emergency trolley was kept in a locked room. Staff told us most midwifery staff knew the lock code, but it was possible some may not in an emergency. Following the inspection staff decided to move the emergency trolley outside of the locked room and we saw evidence of this.

Staff carried out safety checks of specialist equipment. Records showed resuscitation equipment on the unit was checked daily, emergency trolleys were checked and equipment within was in date. The emergency trolleys were unlocked, which presented a risk of unauthorised people having access to equipment and medicines within trolleys. Staff told us this had been risk assessed by the resuscitation team and we saw evidence of this.

There were CTG monitors in each room on the delivery suite. The use of CTGs was not yet integrated into the new electronic patient record or centralised yet, but the infrastructure was ready to link these.

Call bells were accessible to women and birthing people if they needed support.

We randomly sampled electrical equipment and saw electrical safety testing was in-date. The service told us there was annual testing of electrical equipment. We saw the electrical testing records for delivery suite and wards 17 and 19, which showed 61 pieces of electrical equipment had been tested in February 2023, 1 of which had failed. We saw records of preventative maintenance, corrective maintenance and safety checks on medical equipment.

Staff told us the levels of nitrous oxide and oxygen (‘gas and air’) had been checked and were found to be high, but not high enough to warrant the use of scavenging systems currently. These were planned to be checked again in 6 months.

We saw ligature risk assessments had been completed for the various areas of the maternity service in May 2023, except for triage, which was assessed in January 2023. There were snapping blind pulls and cords in the bathrooms.

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

Maternity

Assessing and responding to risk

Staff completed and updated risk assessments but did not always take action to remove or minimise risks. Staff identified but did not always quickly act upon women and birthing people at risk of deterioration.

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 women and birthing people's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included the necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found this information was shared. Staff had 2 safety huddles per shift to ensure staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. We requested audit results for compliance with SBAR and saw results were mostly 100%, with three scores falling into an amber rating, 2 in 2022 and 1 in 2023.

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 electronic patient record system produced a discharge notification for General Practitioners (GPs).

Leaders monitored waiting times. However, they could not always make sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff completed an audit form of triage assessment times for every person attending triage so managers could monitor how well triage was performing. Triage audits showed assessment time frames were not always met.

The triage receptionist routinely sent patient satisfaction survey invitations to women and pregnant people attending triage. This process aimed to identify problems early and results went to the audit team.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration but did not always escalate these situations appropriately. Staff used the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 6 electronic patient records and found MEOWS had been completed. We saw monthly MEOWS audit results from August 2022 to June 2023. These looked at between 21 and 44 records monthly and showed compliances for MEOWS being completed and scored ranged between 91% and 100% (100% in 7 out of 11 months). However, where the MEOWS score triggered a review, this was achieved within the appropriate time frame between 50% to 86% in 5 out of the 11 months (100% in the other 6 months). The action plan for these audits stated incidents had been cross checked for instances of deterioration and none had been identified. In January and February 2023 there were low compliance rates for this aspect (75% and 50% respectively) and according to the action plan 2 out of the 4 actions for non-compliance relating to the deteriorating patient had target dates of August and September 2023. We noted a staff message at the postnatal ward safety huddle that there had been a fall in compliance with MEOWS for deteriorating patients.

Staff completed risk assessments for women and birthing people on arrival using a recognised tool and reviewed this. Staff used an evidence-based, standardised risk assessment tool for maternity triage. A new risk assessment tool had been introduced in July 2022. Compliance with triage assessment time frames between November to December 2022 was 53% for the initial 15-minute assessment, 89% compliance with the midwife assessment and 61% compliance with the doctor review. Triage incident data for March to August 2023 showed multiple reports of breaches in the different assessment time frames. Following our inspection, the service re-audited triage assessment compliance and

improvements were found in the initial 15-minute midwifery review, where compliance increased to 81%. The service identified some challenges with the data and saw doctors were inputting the time when they had completed their assessment and not when it had started. Therefore, the time of the doctor review was adjusted by 10 minutes, the compliance was 75% with this adjustment and 69% without adjustment. Staff told us women and pregnant people could sometimes be waiting for hours overnight for a doctor review. The service told us that women and birthing people would have ongoing assessment by a midwife when waiting for delayed doctor reviews, and that if risk increased during this time, review would be prioritised.

There was a telephone triage service staffed by midwives at the Friarage Hospital. When the Friarage Hospital was busy this line was diverted to the reception desk in the James Cook Triage Unit. At the time of inspection there was no protected midwife at the James Cook Unit to manage this line when diverted, and calls may not always be answered promptly. During normal day time working hours, the line was answered by a receptionist, and callers would need to wait for a telephone consultation when midwives were busy on the unit. Staff told us the advice line was time consuming, they sometimes could not get away from the telephone and it was difficult to keep on top of telephone documentation when also seeing women and birthing people. The line competed with other internal and external telephone traffic, which meant the line may be busy when callers were trying to get through. There was no way to identify or monitor the number of abandoned calls or identify these, and therefore no way to follow these up. This was a risk because pregnant people who may need medical attention may not be able to access advice in a timely way, or not at all.

The quarter 4 March 2023 provider report to the LMNS acknowledged the lack of a dedicated telephone triage line with allocated staff.

Since the inspection the service revised their triage Standard Operating Procedure (SOP). All triage calls should now be answered by a midwife and there would be a designated midwife rostered to cover telephone triage when the service was diverted from the Friarage to James Cook during the day (there is a designated midwife out of hours). They also implemented an answering system where unanswered calls after 5 rings were advised to leave their details and attend the triage unit if concerned or urgent. These unanswered calls also triggered emails monitored by the telephone triage midwife and alerting them to voicemails. Callers who failed to attend triage would be identified from the caller list at set times throughout the day and followed up by phone and repeat callers would be advised to attend the unit if calling more than 3 times in 24 hours. This lack of oversight had been highlighted in an HSIB report from July 2023.

Managers planned to monitor delays and call abandonment rates with weekly reports of unanswered calls, and to review the new triage SOP every 3 months.

Staff did not always know about and deal with specific risk issues. Staff used the fresh eyes approach to carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). We saw the quarterly compliance monitoring for SBLV2 for 2022 to 2023. Between quarter 4 (January to March 2023) and quarter 1 (April to June 2023) we saw compliance ranged between 100% and 96% respectively for use of fresh eyes stickers in labour. During this time frame data showed 96% compliance for appropriate use of the escalation protocol. However, problems with fetal monitoring and CTGs was identified as a repeat theme in incidents.

The dashboard for January to June 2023 showed the target of 95% had not been met for venous thrombo-embolism (VTE) risk assessments in 3 out of the 6 months for both the antenatal and postnatal wards and ranged from 85% to 93% compliance. The trust advised us as part of their factual accuracy review that VTE risk assessments were completed at booking and on admission by the midwife. This was documented on the new electronic patient record (EPR) system

which was introduced in May 2023. Prior to the EPR roll out, VTE risk assessments were completed on paper. In July 2023 VTE risk assessment evidence extracted from the EPR showed compliance of 84.7%. Whilst 15.3% was documented as non-compliant, evidence suggested two reasons for this: During the transition from paper medical records to EPR implementation, not all VTE risk assessments were on the EPR, these were in paper format and, women and birthing people who transferred their care from North Tees, where this EPR had not been implemented, also had paper records.

We saw information which showed bookings by 9 + 6 weeks ranged from 48% to 62% of all bookings. Compliance with carbon dioxide (CO2) monitoring at booking and CO2 monitoring/smoking status recorded at 36 weeks as part of the SBLV2 was below the target of 95% in all 6 months. The SBLV2 compliance with carbon monoxide monitoring at booking and 36 weeks reduced significantly from 92% to 73% between quarter 4 (Jan-March 2023) to quarter 1 (April-June 2023) for booking, and from 84% to 49% between quarter 4 to quarter 1 for 36 weeks gestation. The service was not sure if the compliance levels were due to data entry errors following the transfer to the new EPR system.

We saw a World Health Organisation (WHO) surgical safety checklist audit dated April 2023 for emergency and elective caesarean sections in January 2023. This showed the 100% compliance standard was met in 37 out of the 45 quality measures, which was an improvement from 2022 audits. We saw a WHO checklist audit dated May 2023 for instrumental deliveries in February to May 2023. This showed the 100% compliance standard was met in 3 out of the 46 quality measures with most others ranging from 91-95%, but 11 out of 46 meeting 86% compliance.

We saw the monthly Newborn Early Warning Track and Trace (NEWTT) audit results for August 2022 to June 2023 (excluding October 2022). This showed 100% compliance for these months with NEWTT being completed and scored; however, the data did not contain information about whether elevated scores had been appropriately escalated and numbers were low, ranging from 1 to 10 records audited per month.

Staff told us people attending for IOL would be discussed between the delivery suite team leader and consultant obstetrician to assess risk and priority. However, this was not a formalised process. The trust told us a new IOL guideline and process was presented to the Clinical Techniques, Policies & Procedures Approval Group on 19 September 2023, and introduced on 16 October 2023.

There were processes for women and birthing people who wanted to receive care outside of guidance, which involved seeing a consultant obstetrician and consultant midwife to ensure they were properly informed about risks.

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 told us there was access to a psychiatry team 24 hours a day and 7 days a week for mental health emergencies.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of mental health conditions. There was an antenatal mental health team. This team screened women and pregnant people for risks of mental health conditions. If at risk this person would be reviewed by a psychiatrist, an obstetric consultant and a midwife. The team would provide a mental health birth plan and inform delivery suite about this.

There had been an increase in baby falls from beds on TC, so the service had introduced intentional hourly checks overnight to check safe sleeping practices.

Midwifery Staffing

Maternity

The service did not always have enough staff and staffing levels did not always match planned numbers, which could put safety of women and birthing people and babies at risk.

During the inspection on labour ward the planned staffing was 11 midwives and 2 MCAs, but the actual number was 10 midwives, including the supernumerary coordinator, and 1 MCA. The planned staffing for the postnatal ward during the day was 5 midwives, 2 MCAs, 3 assistant midwifery practitioners (AMPs) and 1 maternity nurse. However, at the inspection the actual numbers were 3 midwives (plus 1 redeployed from delivery suite), 2 MCAs, 1 AMP and 1 maternity nurse. Staff told us the rotas were not fully covered to start with, and ward managers worked clinically, and specialist midwives covered some shifts. The antenatal ward was fully staffed except for having no nurse when there would usually be 1 nurse. Staff told us the antenatal ward was more physically distanced from other areas of the service; managers tried to make sure staffing levels were as planned.

There was an out of hours team of midwives, one of whom would move around to the busiest areas of the service to backfill areas needing more support.

At the inspection triage was fully staffed during the day, however staff told us they would often have triage staff redeployed to other areas. Overnight there was no MCA, and staff said they did not always have an MCA overnight.

Staff told us they did not get breaks; they were rarely fully staffed and were burned out.

The service reported maternity 'red flag' staffing incidents in line with 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. Between July 2022 and July 2023 there were 105 red flag incidents, 102 red flags were delays in IOL and 3 were Labour Ward Coordinator (LWC) not supernumerary (stated as a reporting error as supernumerary is defined as LWC not having a caseload, and these red flags related to helping with clinical tasks).

The service had appointed a recruitment and retention midwife in February 2022 to help with the recruitment of newly qualified midwives and retention of these going forward. Information received stated that in 2023 they had successfully recruited all newly qualified midwives who had trained at South Tees NHS Foundation Trust.

Managers generally accurately calculated and reviewed the number and grade of midwives, nurses and midwifery assistants needed for each shift in accordance with national guidance but could not always meet these requirements. They completed a maternity safe staffing workforce review in line with national guidance in October 2022. This review recommended 214.68 whole-time equivalent (WTE) midwives Band 3 to 7 compared to the funded staffing of 206.14 WTE, a shortfall of 8.55 WTE staff. Managers also completed an assessment of workforce needs in January 2023, taking account professional judgement, acuity data, red flags, fill rates and escalations. This supported a recommended establishment of 225 WTE rather than 214.68. When adding senior and specialist midwifery roles needed for the service, the October 2022 review recommended 236.16 WTE midwives compared to the funded staffing of 223.14 WTE, a shortfall of 13.02 WTE staff.

We saw the monthly results of the acuity tool for January 2023 to July 2023. This showed the service met acuity between 44% and 66% of the time. However, compliance with completing the acuity tool ranged from 58% to 74% over these months.

Maternity

The intrapartum acuity tool results for July 2022 to July 2023 showed acuity was met on labour ward only 55% of the time. The ward-based acuity tool showed inpatient acuity was met only 50% of the time. Compliance with inputting the data into the birthrate plus intrapartum acuity tool, which measures whether staffing levels are safe for the care needed and collects red flag data on labour ward varied. On average it was 70% against a minimum of 85% compliance needed to have confidence in the results for the reporting period July 2022 to July 2023.

There were 196.5 WTE clinical midwives in post, and 12.5 WTE vacancies in the quarter 1 report, June 2023. Staff told us there were 5 WTE midwives starting in September 2023, and they were interviewing for the remainder and using international recruitment.

Maternity leave meant there were approximately 12 WTE midwives off at any one time.

Managers reviewed staffing and activity levels in all areas at the start of the day. The matron of the day visited all areas first thing in the morning to assess staffing and activity levels. There was a meeting of midwifery managers in the morning where staffing, skill mix and known activity in all areas was discussed. We noted staffing was also discussed at safety huddles.

The staffing acuity tool recommended 4 midwives to cover triage. Managers had reviewed triage staffing shift patterns to better match staff cover to patterns of increased activity and demand on triage over the day. These included a 10am to 10pm shift and a 5pm to 1am shift, which staff said was an improvement in cover. This meant triage staffing during the day was 2 midwives from 7am to 7pm, gaining a further midwife at 10am and another at 5pm. However, staff told us 1 of the 3 morning midwives was often redeployed elsewhere.

There was a matron of the day and out of hours lead midwife. The role of these staff members was to try to make sure the right level of staffing and skill mix was available across the service and to act as point of contact for escalation and incidents. They were supported by a SOP, which was introduced in August 2023.

The service had developed a new escalation policy for triage with a clear flow chart for staff to follow when triage was busy and workload exceeded capacity, leading to breaches of assessment times. This formalised the escalation process, making it easy for staff to know when to escalate and empowering them to do so. This involved calling the consultant and manager on call to help in triage to mitigate time breaches.

There was an elective caesarean section list Monday to Friday, with 3 cases scheduled on 4 days and 5 on the other day. We were told category 3 sections may also be added to these lists. Staff told us these lists were very pressurised and felt they did not have enough staff for these to run safely. This was because staff felt the volume and pace of work involved meant there was potential for things to be missed and mistakes made with this level of staffing. There were occasionally 2 midwives for these lists but more often just 1, and if there was a second midwife, they could be redeployed elsewhere.

Overnight if a second theatre team was needed for a second emergency, staff told us this team would come from main theatres.

The service generally made sure staff were competent for their roles. Staff we spoke with at inspection told us they had received an appraisal. We received trust level appraisal data for staff groups. This showed compliances of 82% for registered nursing and midwifery staff against the trust target of 80%.

Staff told us newborn and infant physical examination (NIPE) checks for TC babies would be completed by neonatal staff.

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. Staff told us this happened regularly, at short notice, and sometimes they were expected to work in areas unfamiliar to them, which could be stressful.

The Friarage Birthing Centre midwives were part of the escalation protocol, which meant the Friarage closed, and staff travelled to the James Cook site in times of escalation. Staff told us it could take quite some time to move between sites depending on the time of day.

The number of midwives and healthcare assistants did not always match the planned numbers based on inspection findings. We requested planned versus actual staffing numbers for the different areas of the service for the last 6 months. We received data for fill rates for July to December 2022. Therefore, we are unsure what the more recent situation was.

The service had high vacancy, turnover and sickness rates. Staff told us sickness rates were increasing as staff became more stressed. Data for sickness and turnover rates from August 2022 to July 2023 was broken down by clinical area. On delivery suite the sickness rate was at or above the target of 5% in all months except one, and over 7% in 5 months, being highest in July 2023 at 10%. Turnover rate was above the target of 10% in 9 of these months, being highest in April 2023 at 15%.

On the Maternity Assessment Unit (MAU) the sickness rate was below 4% in all but 3 months, turnover was 6% from May to July 2023, having been around 2% since September 2022. On ward 17 the sickness rate was at or above the 5% target in most months (7), with turnover varying from 4.5% to 8.5%. On ward 19 (including EPAU) sickness was consistently above the target 5% in all months, being over 10% in 6 of the months (highest at about 17%), with turnover ranging from 2% to 9%.

Regular bank (temporary) staff were used to fill some of the staffing gaps. Managers offered an induction to bank and locum staff. The trust had a local induction process and checklist for short term locums or bank staff who had not completed the trust induction process.

Managers generally made sure staff received any specialist training for their role. For example, there was an enhanced maternal care team of 10 WTE midwives. We were told all had completed the Acute Illness Management (AIM) course and received annual training. Staff told us there was always 1 enhanced maternal care midwife on each shift and they were able to manage enhanced monitoring (arterial and central lines) and provide recovery care if needed. There was a critical care lead obstetrician and a maternity critical care meeting every 2 months. All enhanced maternity care (EMC) midwives were required to attend an annual update.

The service had an international recruitment programme and a detailed preceptorship programme for newly qualified midwifery staff, which was said by staff to be very helpful.

Medical staffing

The service generally 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 reviewed and adjusted staffing levels and skill mix and offered locum staff an induction.

Maternity

The service generally had enough medical staff to keep women and birthing people and babies safe on paper. However, we asked for the planned versus actual numbers or fill rates for medical staff to assess how well staffed the service was. There were 18 consultants occupying 16 WTE, as 5 were less than full time.

There was a junior doctor allocated to cover triage from 9am to 5pm Monday to Friday, but their time was not protected because they also covered the antenatal and postnatal wards. This meant doctor reviews could be delayed if busy on the wards. However, we were told the labour ward on call team could cross cover the wards if triage was busy.

Sometimes the triage doctor was a middle grade doctor who could assess all people attending triage, and sometimes a sub-middle grade doctor (a doctor more junior than a middle grade, which includes foundation doctors, trust grade doctors at senior house officer level and first and second year specialty trainees. In relation to triage this did not include foundation year 1 doctors), who were limited in what they were able to assess. NB: A sub-middle grade doctor is not a recognisable role in the wider context of medical roles. This could cause delays when waiting for a more senior doctor to attend. Out of hours triage was covered by the on-call team, which covered all areas of the service. This meant doctors may be busy in other areas when people needed to be seen in triage. Staff told us there were delays in doctors seeing triage patients within the required time frames and audit data showed this, as discussed above.

Following the inspection, the service put in place a middle grade doctor dedicated to triage from 9am to 5pm Monday to Friday, and an additional middle grade doctor on call out of hours from 5pm to 8pm and at weekends to help improve compliance with triage assessment times. We were told the middle grade doctor would be a senior registrar and that triage was overseen by the consultant on call.

There was a separate obstetric consultant who covered the antenatal ward, doctor reviews in the MAU and maternity patients in the rest of the hospital from 9am to 1pm.

The day and night shift on call team had 2 middle grade (1 senior and 1 junior) and 2 sub-middle grade doctors who covered both obstetrics and gynaecology, and 1 consultant. There was a separate consultant covering gynaecology both day and night, which meant the obstetric consultant could focus on obstetrics.

The elective theatre list had a separate team of 1 consultant, middle grade and sub-middle grade doctor, which meant emergency cases were not impacted by elective cases and vice versa from a medical staffing point of view.

We saw data for the annual turnover and sickness rates for combined obstetrics and gynaecology medical staff for August 2022 to July 2023. This showed annual turnover ranged from 28% (June 2023, which was related to rotation of doctors in training) to 5.2% (December 2022) against a target of 10%. This was consistently highest in recent months from March to July 2023, being over 10% in these months. Sickness rates ranged from just under 7% (December 2022) to 0.8% (July 2023) and was most frequently 3-4% during this period against a target of 5%.

Managers offered locums an induction to the service. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

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

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

We received trust level appraisal data, which showed a compliance rate of 98% for medical staff, exceeding the trust target of 80%.

Records

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

Women and birthing people's notes were detailed, and all staff could access them easily.

The service had switched to a fully electronic patient record system in May 2023 from a combined paper and digital system. Staff reported there had been some problems with the new system, for example in saving documentation. This new electronic system was on the risk register.

People who had booked before the new electronic system was introduced still had paper notes. For some people their records were part paper and part electronic, which meant staff could not view the management plan created antenatally on the new electronic system. Theatres used paper records which had to be scanned onto the electronic record.

We reviewed 6 records and found that all risk assessments were complete.

Monthly maternity records audits of the documentation section of record numbers ranging from 31 to 87 showed results ranging from 89% to 98% from August 2022 to June 2023. Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. The last of the paper records on the postnatal ward (held by women and pregnant people booked prior to the new system) were kept in trolleys with a coded lock.

Medicines

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

Staff mostly stored and managed medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff.

Controlled drugs (CD) were stored securely in a coded locked room and the CD keys were kept by the team leader. Intravenous (IV) and other medicines were kept in a locked cupboard in the same room and the keys for this were stored in a locked case.

When part used epidural bags containing CDs were destroyed on the ward, staff did not document where the waste originated from. We raised this with the trust, and a process was put in place following the inspection, so that staff could identify and document where the waste came from.

Medicines fridge temperatures were checked daily and centrally monitored by pharmacy.

We randomly sampled medicines in all wards and found they were in date. Opened liquid medicines were labelled with the date of opening.

Prescriptions on triage were locked in a cupboard in a coded locked room and required 2 staff members to count and sign them out. Staff kept records when FP10 prescriptions (hospital outpatient prescriptions) were issued to patients, however they were not always clear and easy to follow. There was a risk of misuse or diversion of prescriptions. We raised this with the trust, and a new register was put in place to record prescriptions so clearer records could be maintained.

The milk fridge on the postnatal ward was in a coded locked room, the fridge was locked, and milk was dated and labelled. Milk fridge temperatures were monitored.

The emergency trolleys, which contain emergency medicines, were unlocked. Staff told us this had been risk assessed by the resuscitation team. We requested a copy of this risk assessment at the inspection but did not receive it. We noted some inconsistency with other types of emergency trolleys, some of which were kept in locked rooms because they contained medicines or fluids.

Staff generally followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines needed during their admission. We reviewed 5 prescription charts and found staff had generally completed these correctly. However, in 3 of the charts the reason why medicines were not given had not been recorded and 2 out of 5 charts did not have the weight documented for weight dependent medicines.

Incidents

The service managed safety incidents. Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team, however staff were not always able to learn from these due to lack of protected time. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. There was a rapid review meeting for incidents on Monday, Wednesday and Friday. We attended the rapid review of an incident on the day of the inspection. There was also a weekly patient safety meeting which looked at incidents in more detail.

Staff told us that any serious concerns requiring a rapid change in practice would be included in safety briefings. We confirmed our concerns about practices around water births had been passed on to staff as all staff we spoke with were aware of this.

We were told all incidents reported on the electronic system were viewed by the risk and governance lead midwife. The most frequently reported incidents included triage breaches, post-partum haemorrhage (PPH) over 1500mls, third- and fourth-degree tears and readmissions of babies. We were told the opening of a second theatre, instances of inability to get a second theatre team and all postnatal readmissions were also reported.

The service told us there were 7 incidents which had been open for over 60 days. These had been open between 70 and 216 days and were HSIB or perinatal mortality review tool (PMRT) cases still under review.

Maternity

Managers investigated incidents and involved women and birthing people and their families in these investigations. We reviewed some serious incidents, PMRT and HSIB cases and found staff had involved women and birthing people and their families in the investigations.

We did not see any evidence that managers monitored incidents by ethnicity but were told the service could filter incident data by ethnicity if needed.

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. For serious incidents, PMRT and HSIB cases we saw, data provided confirmed duty of candour had been carried out.

Staff received feedback from investigation of incidents but did not always have time to read email-based feedback. Staff were aware of the weekly rapid review of incidents meetings but told us they were usually too busy to attend these, although said this would be facilitated for those involved in an incident. Sharing from learning items were also discussed at safety huddles. There were safety boards displaying learning resources and information for staff throughout the department.

Learning from incident reviews was sent to all staff by email, however, staff often had to read these in their spare time. There was a possibility learning was not passed on effectively as some staff may not always read their emails.

The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff.

Staff could not always meet to discuss the feedback and look at improvements to the care of women and birthing people. Staff told us there were weekly CTG sessions with the fetal monitoring lead consultant by video link, however said it was difficult to attend these when at work. Staff had to watch these sessions in their own time, which they may not always do. The provider could not be assured the CTG learning from cases was effective.

There was evidence that changes had been made following feedback. We saw evidence learning from incidents was incorporated into training.

There was mixed information on management debrief and support of staff after a serious incident. Staff told us there were hot and cold debriefs following incidents. There was a professional midwifery advocate for support. However, we also noted some information within the data suggesting staff had not felt supported following an incident.

Is the service well-led?

Requires Improvement

Leadership

Local leaders had the skills and abilities to run the service on a day-to-day basis. They supported staff to develop their skills and take on more senior roles. They were generally visible and approachable in the service for women and birthing people and staff. However, they did not always understand and manage the priorities and issues the service faced in a timely way.

Maternity

The leadership structure was well-defined and included the head of midwifery (HoM), the deputy chief operating officer, the clinical director (CD) for maternity services and the CD for the neonatal unit. There were obstetric leads for different specialities such as fetal medicine.

Maternity services were part of the Women and Children Collaborative. Assurances were sought by the trust Board via the senior leadership team and the Clinical Policy Group. There were several regular key meetings covering safety issues, workforce, training, culture, patient experience and governance aimed at providing assurance to the board.

In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. The HoM attended board meetings and presented any midwifery papers/reports to ensure the board were sighted on any highlights or issues. The HoM and CD attended the trust Board as required and attended the Quality Assurance Committee (a subsidiary of the board), quarterly.

The chief nurse chaired the Maternity Improvement Board. This raised the profile of maternity services. Links with trust board were reported to be very good and the board were reported to be supportive of all maternity matters, interested and engaged.

The service was supported by 6 maternity safety champions which included a non-executive director. They gathered feedback from walk-abouts and triangulated this with feedback from the Maternity Voice Partnership to make improvements.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress. For example, many of the band 7s had completed a nationally recognised leadership programme.

There were several aspects of the service which suggested leaders struggled to always implement change and improvements in a timely way, although they generally knew what was required. For example, there had been no birthing pool for a sustained period of time, and they recognised a dedicated telephone triage with allocated staff was needed but had not yet been able to achieve this. We saw however, that there was an Estates Overview and Timeline document, which outlined key dates and progress on various areas of the service that needed to be improved. This included where a project or business case needed to be presented and approved.

Vision and Strategy

The service was developing a detailed vision and strategy. The draft vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a draft vision for what it wanted to achieve and a draft strategy to turn it into action, developed with all relevant stakeholders. They were developing the vision and strategy in consultation with staff at all levels. The strategy was dated 2023 to 2027 and provided a comprehensive 5-year improvement plan which clearly set out aims, objectives, and benchmarks to monitor progress. Some areas of the strategy document were yet to be completed and it was not clear when the draft would be ratified for use and circulated widely.

Leaders told us they were working closely with STRIVE (their educational centre) and developed an online feedback tool so staff could give feedback on what they thought their vision and strategy should include. Leaders also told us the Maternity Voice Partnership would share the approved draft on social media channels, so potential users of maternity services could also contribute. We were told the final version had to have sign-off by staff and the public.

Maternity

The vision was recorded as 'to provide excellent and evidence based holistic person-centred care throughout pregnancy, birth and the postnatal period. Working in partnership with birthing people to ensure their requirements were met with kindness, compassion, respect and understanding.

Culture

Staff generally felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity and provided opportunities for career development. The service generally had an open culture where women and birthing people, their families and staff could raise concerns without fear, although this had not always been the case.

Most staff felt respected, supported, and valued**.** They were mostly positive about the department and its leadership team and felt able to speak to leaders about difficult issues.

In a meeting in May 2023, cultural issues were cited by HSIB as an improvement need. They found staff felt unsupported following involvement in incidents, poor access to debriefs and unkind comments from colleagues were reported. Staff said they were not able to attend patient safety meetings and learning from incidents was not completed or shared effectively. The trust had developed an overarching HSIB and serious incidents (Maternity) checklist after HSIB fed back to them. This was put in place to support shared learning with all staff members.

The service had an action plan to improve culture which incorporated additional staff training, staff engagement, the professional midwife advocate role and collaboration with external partners such as Freedom to Speak Up and NHS England. At the time of inspection, 7 out of 17 items had been completed and 10 out of 17 were on target for completion in 2023-2024.

There were 3 Freedom to Speak up Guardians at the trust. Maternity services had won a recent trust award for the service that had shown the most improvement in staff speaking up.

Staff did not always know how to acknowledge and deal with complaints. Complaints were not managed in a timely way. When women and birthing people made complaints, the service investigated what went wrong. We saw response letters were sent more than 4 months following receipt of the complaint. This was not in line the trust policy and did not support timely learning and improvement from feedback. We saw response to complaints letters were impersonal and did not offer compassionate concern or understanding to women and birthing people. Action planning to improve areas of the service identified in complaints was ineffective, as complaints had common recurring themes over time. Communication with staff to minimise recurring these themes was not demonstrated to be timely or effective.

We noted there were several repeated themes in serious incidents, PMRT and HSIB cases. This again suggested the service struggled to effectively get to grips with problematic areas in a timely way.

The service had several external stakeholder reports in the year before the inspection, including NHS England (NHSE) screening service and professional wellbeing reports and UNICEF Baby Friendly Initiative. External reports all commented on high levels of staff satisfaction, happy, dedicated and cohesive teams. The service was part of a pilot scheme for introducing restorative and just culture and this had been recognised in reports and by staff and leaders as taking positive steps to improve.

Maternity

The South Tees Way Resolution Pathway had been developed and implemented across the trust. This gave an opportunity for all parties to secure an outcome to a grievance, dignity at work or code of conduct concern or an incident through open, constructive, and restorative conversation.

The pathway could be initiated in response to any adverse event. Such an event could have harmed or did harm to individuals or groups, and the harm may have been psychological, physical, reputational or damage to property. Line managers were responsible to attempt to resolve the situation as early and constructively as possible, usually in the form of an early resolution meeting.

Leaders told us the Trust Board were committed to the Civility Saves Lives campaign and training sessions raised awareness about the impact of civility and incivility on staff and safety outcomes.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. There was a public health midwife and public health team in the local authority and the safety champions told us they focused on reducing risk and inequalities for vulnerable women and birthing people.

The service promoted equality and diversity in daily work and had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement, and staff told us they worked in an inclusive environment.

Governance

Leaders did not always operate effective governance processes. Staff at all levels were generally clear about their roles and accountabilities. However, although there were regular opportunities to meet, discuss and learn from the performance of the service, staff could not always attend.

The trust advised us that the maternity governance framework had a significant review and redesign in early 2022, with version 1 of the new governance framework being introduced in April 2022. This framework showed the differing levels of governance and different meetings which were accountable for service delivery, effectiveness, quality and safety. A framework was introduced using quality improvement methodology (PDSA cycle) and to ensure effective use of resources and reporting requirements (LMNS, Maternity Incentive Scheme). The service and trust Board assurance had been regularly reviewed by the maternity leadership team and patient safety champions. There had been regular reviews of the governance framework to react rapidly to feedback and adjust as required to ensure effective and efficient systems and processes. The governance framework was reviewed in September 2022, November 2022, February 2023 and October 2023.

We saw maternity safety champions met approximately every 2 months. Maternity safety champion meetings provided board level assurance, with a clear structural flow between other associated governance groups. There were several standing agenda items for discussion, such as key performance indicators, recruitment and retention, the maternity incentive scheme and escalation. Meeting minutes did not always record actions for follow-up, dates for completion or progress updates and this may result in slow or ineffective governance processes. For example, in February 2023, the meeting discussed readmissions for wound infections, but there was no further discussion on outcomes and mitigations. The meeting identified an area of non-compliance in carbon monoxide monitoring at antenatal booking

appointments and with breastfeeding rates, but these issues were not followed-up on at subsequent meetings and there was no mention of mitigating actions taking place. Minutes showed positive and effective learning from events that happened both internally and externally to the service, including following never-event protocols to manage and report a near-miss of a potential foreign body following a surgical procedure.

We reviewed Trust Quality Assurance Committee minutes and saw information therein included for example, the maternity dashboard, safety incidents, Maternity and Neonatal Voices Partnership Quarterly Report and the maternity survey results. We saw serious incidents, key performance indicators and various levels of assurance from audit were all discussed. There was evidence the service had requested to rescind the declaration of an incident as a formal 'serious incident' and the rationale for this was not clear. Without recent documentation it was not evident that mitigating actions had taken place or been effective at improving service delivery. For example, the percentage of avoidable repeats of newborn blood spot screening which was 2.4% against a national target of 2%, late antenatal booking appointments, and incomplete documentation for antenatal screening tests.

The Maternity Quality Assurance Committee meeting discussed topics such as serious incidents, perinatal mortality reviews, compliance against the Saving Babies' Lives care bundle and Avoiding Term Admissions Into Neonatal units (ATAIN). All unexpected term admissions to the neonatal unit were reviewed as individual cases at a weekly ATAIN meeting or rapid review. This was an MDT meeting. The trust told us immediate learning was identified and shared with staff via one-to-one feedback, learn and share, and safety huddles. Learning and actions implemented include:

Appropriate escalation of CTG concerns (monitored via a fetal monitoring audit). A quarterly ATAIN report summarised the ATAIN numbers, themes, and actions. This was discussed and presented at steering group meetings and the Trust Quality Assurance Committee (QAC) which was a sub-Board committee. The report was also sent to the LMNS.

Maternity services were compliant with all Perinatal Mortality Review Tool reporting requirements as per Maternity Incentive Scheme standard 1. All cases had an MDT rapid review within 5 days of the incident to identify and implement any immediate learning. There were 12 cases reported for the Perinatal Mortality Review Tool (PMRT) between January and March 2023, 9 of these were eligible for routine PMRT review within the service. The service had chosen to delay full discussion of these cases until the next quarterly meeting to allow for the results of all necessary investigations. When cases were discussed at meetings, we saw most notes were detailed, learning was identified, and comprehensive action plans were developed.

The service shared Maternity Safety, Quality and Effective Care Group Meeting minutes with us, and we saw meetings were not always at regular intervals. We asked for the most recent meeting records and the service provided 8 sets of meeting minutes dated August 2022 to July 2023. They also provided a review of the meeting's effectiveness. This document recommended reviewing the cycle of business and terms of reference to ensure effectiveness, and to look at ways of improving core membership attendance rates.

There was a Clinical Effectiveness and Education Group (CEEG) for maternity services which monitored current risks and challenges, guidelines, audits and progress of various ongoing workstreams. The meeting identified when the service became an outlier on PPH above 1500mls and acted quickly to determine any underlying cause. In June 2023 the meeting noted poor compliance with Gap and Grow training for midwifery staff (15%) and there was no action plan discussed or evident at the meeting to improve this. However, the trust advised us the training was affected by the need to purchase the licence for GAP GROW 0.2. The GAP grow training had been re-launched just before the June 2023 Clinical Effectiveness and Education Group (CEEG) meeting and therefore training figures would not have been reflected at that time. There was a live action log for the CEEG meeting to monitor and track progress and performance to support effective governance processes.

Maternity

The service audited compliance quarterly with Saving Babies' Lives care bundle version 2 (SBLv2), a national plan of care to minimise stillbirths and neonatal deaths. The service achieved 100% compliance against a target of 95% for the year preceding the inspection.

The service used a perinatal quality surveillance tool which allowed leaders to view key information about the service at a glance, including staffing status, training compliance, nationally reportable incidents and others.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

Maternity services had a triumvirate leadership team who met regularly. Meetings were not formally minuted, although the service provided brief logs of discussions for the 3 months preceding the inspection. This showed triumvirate meetings discussed immediate safety concerns and current tasks facing the service. Each discussion topic had a professional owner who was responsible for managing related work, and documented stakeholders for consultation, for example, implementation of a digital midwifery team. Topics were updated to show progress and completion.

We saw evidence of discussion and approval of new techniques or procedures which had been presented at the Clinical Techniques, Policies and Procedures Approval Group (CTPPAG). The service held audit and teaching meetings approximately 10 times a year. We saw information related to audit and teaching meetings for obstetricians in November 2022 and February 2023. We saw results and learning from audits were discussed.

The layout of the unit was not in line with national recommendations. Women and birthing people having fertility treatment or requiring early pregnancy and miscarriage care were seen for scans in the antenatal clinic. The impact of this was patients being subjected to psychological distress and the service did not make adequate effort to mitigate and avoid this happening. We saw complaints had been made about the layout of the unit and the service response was to add a sentence to the appointment letters asking women and birthing people to request alternative arrangements if they were not comfortable. This put responsibility on the patients which was not appropriate and created an issue with access to appointments held in a safe, appropriate and dignified environment.

In 2023, the service had changed its pathway for vitamin K (a medicine to help reduce blood clotting disorders in newborns) administration for babies following an adverse incident which showed a positive response to safety incidents.

Leaders monitored 'red flag' events, which was a proactive tool indicating something may be wrong with maternity staffing, for example, lack of supernumerary status of the delivery suite shift leader, or a delay to induction of labour or epidural. Delays in induction were red flagged as per national recommendations and included if the woman and birthing partner waited more than 2 hrs after admission for the start of the process or 6 hours for any further steps in the process. We were told the delays were kept to the minimum. In the last 24 months there had not been an incident related to delays in induction and only 1 delay in August 2023.

Workforce reports were reviewed by the Peoples Committee. Monthly and quarterly maternity reports were reviewed at the Quality Assurance Committee and assurance was reported upwards to the trust Board. Information provided to us

showed there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from January to June 2023. It was clear that the RAG rating for actual midwifery staffing levels for January to June 2023 showed the gaps in roles. We could see too information on recruitment and how such gaps were mitigated, including offer to agency provision.

The service had also implemented an acuity tool which showed between July 2022 and January 2023, the service had enough staff 55% of the time. However, compliance rates for use of the tool were below the recommended 85% target rate to provide assurance on data accuracy. The service recognised this was an issue that required embedding and said matrons were working to support shift leaders to ensure the acuity tool was used appropriately. During this reporting period the service recorded 105 red flag events, 102 of these were delayed inductions of labour. It was not clear what the service had done to mitigate the risk of persistent delays to inductions.

A staffing template review was carried out in October 2022 which showed a deficit in whole-time equivalent (WTE) bands 3-7 of 8.55. The review predicted a further 13.02 WTE bands 3-7 were required to meet future demands on the service including if continuity of carer was implemented and to allow for increased complexity of women and birthing people accessing care. The service monitored when closures happened due to acuity concerns. Staff were shared between James Cook University Hospital maternity unit and The Friarage Maternity Centre (standalone birth centre in Northallerton), and The Friarage frequently closed due to redeployment of staff to James Cook maternity services. Between July 2022 and December 2022, The Friarage closed on 73 occasions, of these, 66 occasions were due to staff shortages and acuity of the unit at James Cook. James Cook maternity unit closed on 4 occasions during the same time period. Between January 2023 and July 2023, the Friarage closed 55 times due to cross-site staffing. James Cook maternity unit closed on 3 occasions between January and July 2023. Leaders said most closures happened overnight when there was no specialist or senior midwives to assist with clinical workload, which was indicative of over-reliance on specialist and non-clinical staff and ineffective on-call systems or escalation processes. The service performed rapid reviews when the unit closed. The decision was made jointly by the multidisciplinary leadership team and the Local Maternity and Neonatal System (LMNS) was notified. Points for review and learning were documented on rapid review proformas shortly after closure occurred. Women whose care was diverted were offered formal apologies.

In May 2022 the service had an assurance visit in relation to initial and immediate safety actions recommended in the Ockenden report (2022) which found all 7 actions were being met. Following the assurance visit by the regional team, additional suggestions were made to further enhance services. The LMNS reports dated June 2023 for the service stated 2 out of 7 actions were only partially met: risk assessment and informed consent. There were actions in place to achieve compliance, although there was no timeline or dates provided for when this would be achieved. Since the inspection, the trust has told us all actions have concluded.

There was evidence that serious incidents were reported to and monitored by the Local Maternity and Neonatal System. Documents dated June 2023 were shared as part of the inspection and showed 3 cases were presented and reviewed. We saw learning and recommendations following specific serious incidents were identified and communicated to staff.

The service identified and monitored key overarching themes within incident reports, PMRT reports, and HSIB reports and reported findings to the LMNS for review. In June 2023 the service reported delays in triage, readmissions to hospital following discharge (both maternal and neonatal), unexpected admission to the neonatal unit and PPH over 1500mls as key themes from staff incident reporting. Themes from HSIB reports were fetal monitoring, risk assessment and clinical escalation, and themes from PMRT were appropriate provision of translation services and placental histology investigations. However, there was no further information provided about how these themes had been mitigated against or resolved.

Maternity

We saw the quarterly provider reports to the LMNS for quarter 3 (December 2022), quarter 4 (March 2023) and quarter 1 (June 2023). These showed the identification of themes from incident reports, PMRT cases and HSIB cases. There were several themes which repeatedly came up. These were unexpected readmission to neonatal unit, readmission of mother, triage delays, translation services, fetal monitoring/CTGs and escalation, assessment and clinical oversight. There was a summary of safety interventions implemented but no further information on time frames, monitoring and auditing of these interventions. This data gave rise to the concern that leadership struggled to make effective interventions to remedy repeated problems which had appeared over 3 quarters' worth of provider reports.

Dynamic risk assessments were undertaken by the QA midwife with the relevant personnel who had raised the risk. A new risk was then opened on the risk register. The initial risk grading was based on no mitigations, controls, or actions. Mitigations, controls and actions were then identified with a target risk rating. Every month, the QA midwife led a review of all open risks. Current risk ratings, mitigations, controls and actions were reviewed and updated. The risk rating was updated or closed as appropriate. A summary of the risk register was presented and discussed at steering groups and was also displayed for staff on the Quality Boards and in the Quality and Safety Briefing.

Leaders managed and monitored ongoing and emergent risks via a risk register. At the time of inspection there were 17 risks on the register. The top risk was staffing, which had a score of 16 out of 20 and was classed as extreme. To mitigate this risk the service was commissioning a new staffing template review and had ongoing recruitment plans. Other recognised risks included the environment for IOLs, delays within the triage service and non-formalised provision of a triage telephone line. The service mitigated risks by completing re-audits, reviewing pathways and completing deep cleans. Action logs were detailed and were updated to reflect progress, with responsible persons identified and timelines attached.

The service had quarterly meetings with HSIB to discuss recent referrals and themes identified in incidents. Referrals to HSIB from South Tees were in line with national data. Top recommendations to the trust following HSIB referrals were around clinical oversight and escalation, particularly in relation to fetal monitoring and induction of labour and ensuring holistic reviews of women and birthing people were made. The service had developed action plans to address areas of learning. These detailed the action, a responsible person and time frame for completion. A red, amber or green rating was assigned to each action.

The service used a comprehensive review tool for babies admitted to the neonatal unit unexpectedly. This allowed leaders to monitor and manage performance against the ATAIN initiative.

The service had introduced specific teams and care pathways in response to health inequalities identified in their population demographic. Specialist midwives were appointed in preterm birth and fetal medicine in line with national recommendations, and the service followed regional guidelines for preterm birth prevention. Between October 2022 and March 2023 an average of 9% of births occurred before the 37th week of pregnancy, which was above the national target of less than 6% by 2025. The service had fully implemented the Saving Babies Lives version 3 bundle and had several actions in progress to help them meet the target.

NHS England performed a quality assurance visit of the antenatal and newborn screening unit in March 2023. It was noted the screening unit was generally well run and there were no immediate concerns or urgent recommendations. The report identified a lack of consistent interpretation services and a lack of focus on health inequalities. Several recommendations to the service were made regarding timeliness of screening tests, governance and oversight of referrals and testing. The service had developed an action plan to implement improvements.

Maternity

The service was working towards reaccreditation of UNICEF Baby Friendly Initiative (BFI) to support accurate support and information with women and birthing people about feeding their babies. The service was inspected by BFI in May 2023, which found the development of a decision tool (a flow chart to help ensure informed maternal choice and adequate wrap around breastfeeding support) was a particular area of good work. The report identified some areas for improvement including the feeding pathway for high-risk babies and hypoglycaemia (low blood sugar) in newborns, which did not follow all national recommendations and there was no rationale for this. An action plan had been developed to progress identified improvements including updating the pathway for high-risk or hypoglycaemia in newborns.

After implementation of a prioritisation and risk assessment tool in maternity triage, the service received an implementation progress report which identified areas for improvement, including streamlining patient flow and minimising inappropriate admissions.

Information Management

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

Maternity services had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Data or notifications were submitted to external organisations as required. This included the National Neonatal Audit Programme, Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) and Maternity and Newborn Safety Investigations Special Health Authority.

They had also completed the national perinatal review tool since the launch. This helped to ensure consistency of reporting nationally.

Engagement

Leaders and staff 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.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP held regular meetings and there was an ethnic diversity sub-group to focus on particular issues and health inequality faced by women and birthing people from ethnic minority groups, including asylum seekers and people who do not speak English.

The service made available interpreting services for women and birthing people and collected data on ethnicity, but translation service problems were a repeat theme in incidents. The trust used a translation service to support women and birthing people who had requirements for verbal communication in alternative languages. The uptake rates were provided to us and showed a significant improvement in the ‘in person’ support since April 2023, above 80%, and a static rate of telephone support in excess of 90%. The trust had a range of leaflets available in different languages, examples of which we saw.

Maternity

The service monitored results of the NHS staff survey and there was an action plan to improve on responses given in the 2022 survey. Survey results for maternity and gynaecology were collated together and were comparative with those for the organisation as a whole. The service had identified areas where scores had dropped from the previous year and how to tackle this. Action planning included improvements in HR processes, flexible working and retirement options, car parking provision for staff, culture and psychological safety training sessions, band 7 leadership development and others.

Maternity services had an internal communication and engagement plan which described how the service communicated with staff. The service engaged with staff including newsletters covering current issues or updates such as bereavement, recruitment, and digitisation. The service shared feedback from women and birthing people with staff, and encouraged patient feedback via email, text messaging and QR codes. The service shared key safety and quality messages with staff, including the risk register so staff could see governance work, processes used, and progress made by leaders to tackle challenges within the service. 'Monday Messages' were short bulletins used to share news weekly, and the service also created safety messages on a regular basis. However, although we saw this evidence of engagement processes, it was not clear how the service assured itself that all information reached staff, given that some channels of communication were reliant upon staff accessing this information in their spare time due to a shortage of protected time for this.

We did not receive any responses to our give feedback on care posters which were on display during the inspection.

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.

Staff were committed to learning and improving services, but the service did not always afford them the ability to participate fully in this, and many said they had to complete learning in their spare time. Leaders told us they had invested in training and educational opportunities, that all staff would have mandatory and role specific training, and that compliance with this training was over 90%. However, this may still need to be completed in spare time, and learning processes outside of mandatory and role specific training, for example from incidents, cases or audits, may be less accessible. Staff had a good understanding of quality improvement methods and the skills to use them. There was evidence the service wanted to improve by learning when things went well or not so well, but this was not always effective, and problems persisted despite this.

Outstanding practice

We found the following areas of outstanding practice:

- Leaders were highly responsive and engaging in relation to the concerns raised by CQC during the inspection and acted promptly to improve the safety of the service. This represented an example of a service being transparent and accountable and working in partnership with the regulator towards our shared goal of improving maternity services.
- Memory boxes for birth parents and foster carers if a baby was to be placed into the care of the local authority. This aimed to support parents through the potential grief of not going home with their baby and promote the start of an ongoing connection during safeguarding proceedings.

Maternity

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 staff complete regular skills and drills training. (Regulation 12)
- The service must review the escalation or surge process to ensure that on call rota is effective and there is not an overreliance on specialist midwives which impact negatively on staffing out of hours. (Regulation 18)
- The service must monitor compliance with the calculation, escalation and timely review of MEOWS and take action to improve compliance, and ensure instances of deterioration are identified and actioned promptly (Regulation 12)
- The service must ensure all governance and risk concerns are followed up and any mitigations applied are effective and reviewed. (Regulation 17)
- The service must address the environmental and equipment shortfalls that affect the safety, privacy and dignity of women, birthing people and babies (Regulation 15)

Action the trust SHOULD take to improve:

- The service should ensure staff are trained in safe birthing pool evacuation.
- The service should ensure all medical staff complete safeguarding training.
- The service should ensure full security of delivery suite and fit for purpose birthing pools and evacuation equipment if water births are to be offered as an option.
- The service should continue to improve on triage processes and monitoring through audit.
- The service should continue to explore ways to improve the current staffing challenges.
- The service should consider alternative ways to communicate learning with staff in addition to email.
- The service should complete the work on the vision and strategy for maternity services.
- The service should monitor incidents by ethnicity.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, 2 midwifery specialist advisors and an obstetrics specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.