Northumbria Healthcare NHS Foundation Trust

Northumbria Specialist Emergency Care Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Northumbria Specialist Emergency Care Hospital

Good 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Northumbria Healthcare NHS Foundation Trust.

We inspected the maternity service at Northumbria Specialist Emergency Care 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.

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

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

- Our ratings of the Maternity service have not changed the ratings for the hospital overall. We rated safe and well-led as good and the hospital as good.

Northumbria Specialist Emergency Care Hospital provides a maternity service in the hospital and community to women and birthing people in Cramlington and surrounding areas north of Newcastle, and in the wider rural community of north and west Northumbria. Staff at the hospital delivered 3150 babies between April 2021 to March 2022.

We also inspected one other maternity service run by Northumbria Healthcare NHS Foundation Trust. Our reports are here:

Hexham General Hospital – Hexham General Hospital - Care Quality Commission (cqc.org.uk)

How we carried out the inspection

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions. You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Maternity

Good ➔➔

We last carried out a comprehensive inspection of the maternity and gynaecology service in May/June 2019. The service was judged to be good overall. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people. There was usually enough staff and leaders had a well-defined process in place to reduce the impact of any short staffing. They understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services very well using reliable information systems and supported staff to develop their skills. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff understood the service's vision and values, and how to apply them in their work. They were proud to work at Northumbria Specialist Emergency Care Hospital. Staff felt respected, supported and valued. They were focused on the needs of women receiving care, provided personalised care and were proactive in addressing concerns.
- The leadership team understood and managed the priorities and issues the service faced. They promoted an open culture of multi-disciplinary team working and learning. There was a strong organisational commitment towards equality and inclusion across the service and all staff demonstrated a commitment to best practice care.
- The service engaged well with women, birthing people and the community to plan and manage services, with a clear commitment from leaders to ensuring constructive engagement. All staff were committed to improving services continually.

Is the service safe?

Good ➔➔

We rated Safe as good.

Mandatory training

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

Nursing and midwifery staff received and kept up-to-date with their mandatory training. An average of almost 90% of staff had completed all 6 mandatory training courses/days against a trust target of 85%. Two practice development midwives and preceptorship lead midwives supported midwives and other staff to complete and update their training. They were required to implement a variety of practice development initiatives as well as contributing to the training programme. The trust provided staff with paid time to complete required training and managers made sure this time was included in staffing arrangements.

Maternity

Preceptorship lead midwives had developed a complete preceptorship training package to ensure newly qualified and student midwives were fully supported. This included supporting all midwives to complete a practice supervisor course and 96% of midwives to obtain a practice assessor qualification. This enabled midwives to work with student midwives and act as sign off mentors, which meant student midwives had confidence they would be able to complete their assigned tasks and not have to wait for specific staff to sign them off as competent.

Medical staff received and kept up-to-date with their mandatory training. Eighty seven percent had completed all mandatory training courses.

The mandatory training was comprehensive and met the needs of women, birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and babies.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts so they knew when to renew their training or to attend training sessions. Attendance was monitored by the professional development midwives, who were able to book staff on new training quickly if initial sessions were missed.

The service made sure that staff received multi-professional simulated obstetric emergency training. Data provided by the trust showed all clinical staff received obstetric emergencies skills training and completion rates were above 90% for both midwives and medical staff. Completion of Practical Obstetric Multi-Professional Training (PROMPT) was monitored by the trust's practice development midwives and local leads were notified about required training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed that just over 87% of staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. This met the trust's target of 85%.

Training was given by specialist safeguarding staff and included examples of harm, discussions, sharing information, how incidents are reported in the trust and actions that had been taken as a result. The safeguarding lead midwife told us all midwives also undertook safeguarding supervision every 6 months with a safeguarding supervisor, or more often if they were new staff. This ensured all staff had a working knowledge of safeguarding.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. They gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women had birth plans with input from the safeguarding team to keep them safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. There was a safeguarding clinician or advanced safeguarding trained manager based at the NSECH site who was available 24 hours a day, 7 days a week.

Patient records detailed where safeguarding concerns had been escalated in line with local procedures. Following a cluster of reported incidents between April and October 2022 where safeguarding information was not available, not stored in the correct location or referrals were not made, the service completed a thematic review of records. This identified a range of reasons for these omissions and learning for staff.

The review also identified a requirement for better communication between agencies if safeguarding concerns were found. The service worked with the designated nurse for safeguarding at the previous CCG to develop a 'sharing information regarding safeguarding' (SIRS) process. This enabled them to record information and make referrals to GPs for information, social services electronically and take part in meetings to help keep the baby safe. Following the development of the electronic process SIRS was highlighted and introduced regionally to other safeguarding partners and as part of the national Child Safeguarding Review Panel.

Staff followed the baby abduction flow chart and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored by ward clerks or midwifery staff. The service had practised what would happen if a baby was abducted within the 12 months before inspection. During the inspection we observed staff followed safe visiting procedures.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Leaders completed regular infection prevention and control and hand hygiene audits. Cleaning scores between December 2022 and February 2023 showed staff consistently performed well for cleanliness. Where there were exceptions, the trust implemented a cleaning action plan to address identified concerns.

Data showed hand hygiene audits were completed monthly in all maternity areas. Most areas regularly achieved scores of 100% compliance each month. Where issues had been identified, they had improved on the following audit.

All areas of the maternity service we visited were visibly clean, cleaning staff explained their schedules, which included cleaning all areas every day. They told us there were cleaning staff present every day and evening and an on-call cleaner overnight. One cleaner told us if the overnight cleaner was used, day staff made it a priority to check the area so they could tick it off their list.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff made sure their clothing was bare below the elbows and all areas stocked PPE at various intervals along walls. Leaders monitored the rates of hospital-based infections, such as common transmissible bacteria, such as E Coli, MRSA or Clostridium Difficile.

Staff cleaned equipment and couches after contact with women and labelled equipment to show when it was last cleaned.

Environment and equipment

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

Women could reach call bells and staff responded quickly when called. We saw that call bells were within easy reach and staff responded quickly when these were rung.

The design of the environment at the hospital followed national guidance and supported patient flow. The maternity unit was fully secure with a monitored entry and exit system. There was a monitored buzzer entry system to the maternity units and reception areas. These were staffed 12 hours a day, 7 days a week. The service had dedicated maternity theatres and transitional care beds for women, birthing people and babies requiring a higher level of monitoring after delivery. All maternity areas were located on the same floor and close to the main theatre suite.

Staff had developed a bereavement room as of the delivery suite, which women and birthing people could access. The room included tea and coffee making facilities, equipment for bathing babies and a cold cot so parents could spend time with their baby, as well as relevant literature. This was a recommendation in the Stillbirth and Neonatal Death charity (Sands) position statement (Bereavement care rooms and bereavement suites 2016). However, the location of the room was not ideal as it was located in the birth centre, with other birthing rooms and without an alternative route to enter or leave, risking grieving parents overhearing or seeing labouring women, birthing people or babies.

Staff carried out daily safety checks of specialist equipment. Records showed that staff checked resuscitation equipment for both adults and newborn babies outside maternity theatres daily.

Staff regularly checked birthing pool cleanliness and the service had a contract for testing for Legionnaires' disease.

The service had suitable facilities to meet the needs of women and birthing people's families. The partners of women and birthing people were supported to attend the birth and provide support. All rooms on the combined antenatal and postnatal ward were individual and partners who were able to stay had a put-up bed to sleep in.

The service had enough suitable equipment to help them to safely care for women, birthing people and babies. In the birthing centre there were pool evacuation nets in all rooms and on the pregnancy assessment unit (PAU) there was an ultrasound scanner and cardiotocograph (CTG) machines. There were enough individual pieces of observation monitoring equipment throughout the service to ensure staff were able to take pulse and blood pressure recordings when required.

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

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

The trust's safeguarding team and midwife had set up a multi-disciplinary team to work with other agencies involved with vulnerable women and substance misuse. The trust staff identified an increase in cocaine misuse in pregnancy in a particular area where this hadn't previously been an issue. In response they campaigned to look at the effects of this and how to increase awareness in areas with the highest use. They developed an easy-to-read poster and displayed it in these areas, they developed a new webpage specifically with information about drug and alcohol misuse during pregnancy. They developed social media information and had nearly 400 views of video messaging in this way. The service used television, radio and the local press coverage to not only put out the message of the dangers for the fetus but also that women and birthing people would not be judged and staff were there to help.

Staff were supported with comprehensive clinical guidance that ensured a clear pathway for them to follow and included arranging multidisciplinary meetings throughout the pregnancy journey, and involving the women, birthing person and their family. The service trialled a check of information to see if any of these vulnerable women or birthing people had not already been identified, with positive results that methods already employed were effective. Although initially the trust found there was another increase in the number of women and birthing people who used cocaine in pregnancy, the overall effect of this outstanding piece of work has shown a reduction in cocaine use in pregnancy in 2023.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed 8 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff if needed. Staff completed a quarterly audit of 25 records to check they were fully completed and escalated appropriately. The audit for December 2022 to March 2023 scored 100%. MEOWS recorded electronically were also available on the electronic trustwide electronic system if they met certain criteria, if the score was high, for example. The trustwide electronic system sent out an automatic alert to the obstetric team and the critical care outreach team, which improved timely reviews of deteriorating women and birthing people.

Staff completed assessments for each woman, using recognised tools, and reviewed these regularly, including after any incident. The service completed regular audits of patient records to check clinical observations were fully completed and escalated appropriately. Venous thromboembolism (VTE) assessments were completed regularly throughout women and birthing people's antenatal and postnatal journeys. The service had a dedicated antenatal clinic for women and birthing people with high risk VTE scores, which ensured they were seen by the appropriate staff to assess specific risks to them and prescribe treatment. The service's WHO theatre checklist audit for April 2023 showed that VTE assessments were completed in theatre 95% of the time. We saw that action was taken to reduce these risks. Staff followed a bespoke pathway for women and birthing people with gestational diabetes, which ensured they were supported by increased contact with specialist midwives to monitor their condition.

The WHO theatre checklist audit identified good overall practice compliance with completion of the safe surgery checklist. Most areas had 90-100% compliance but where this was not achieved a recommendation had been made. National guidance, 'fresh eyes' checks, require a second check to review Cardiotocographs (CTGs) every hour. A review of compliance in December 2022 showed staff had achieved 100% compliance with safe CTG monitoring. All staff received training in both adult and neonatal life support, and in recognising sepsis in adults and babies. This was part of PROMPT training, which over 90% of midwives and medical staff had received.

Maternity

The service had a second theatre available for emergency caesarean section or other surgery as well as a theatre for elective caesarean sections.

Staff knew about and dealt with any specific risk issues. We reviewed 8 maternity care records. Risk factors were highlighted, for example, women and birthing people with a high body mass index, living in a deprived area, or those with comorbidities. All women and birthing people were allocated to the correct pathway to ensure the correct team were involved in leading and planning their care. Their risk assessments were completed at every contact and there was evidence of appropriate referral.

Women or birthing people who chose to give birth in a way that was outside of clinical guidelines were supported. They were offered appointments with a consultant obstetrician and midwives from the maternity partnership team available to support them. The aim was to support women and birthing people's choice and to ensure the birth was as safe as possible. The service also had a maternity partnership pathway to standardise the documentation and discussion of care plans for women who requested maternity care outside of clinical guidelines.

The service worked with the Maternity Voices Partnership (MVP) to develop information to better support women and birthing people with a large for gestational age (LGA) presentation. Two decision making tools were developed; one for women and birthing people with diabetes and one for those without diabetes. These tools allowed women and birthing people to make safe and informed choices about their care and birth plans. The tools had been recognised by the local Integrated Care Board and there were plans for them to be adopted throughout the Northeast and North Cumbria region due to the lack of national guidance.

Managers monitored waiting times and made sure women and birthing people could access emergency care and treatment when needed and within agreed timeframes. Staff RAG (red, amber or green) rated all women and birthing people who attended the PAU, dependant on their clinical need and urgency. Staff contacted the obstetric on-call team if a woman or birthing person needed a review and information provided since this inspection shows this was mostly completed within recommended timeframe guidance.

The service introduced a structured obstetric triage system in April 2022 to support the move from a traditional triage where women and birthing people were often seen in the order in which they arrived. An audit completed 9 months after this introduction found 79% of women and birthing people were triaged within 15 minutes of arrival, 92% were seen by a doctor once they had been triaged. The doctor was appropriately qualified for the risk rating given at triage 95% of the time. The audit identified the 5% of women or birthing people who were not seen by the appropriately qualified doctor was due to the person self-discharging from PAU. An obstetric registrar was allocated to the PAU each day so there was medical assistance immediately if required.

There were 4 midwives working on 92% of the shifts audited and 2 midwives working on the other 8% of shifts. Staff told us they were also supported by a maternity support worker each shift. Staff said they received training to work in the PAU and had to complete specific competencies before working there. This included training in bladder scanning and ultrasound scanning to further reduce the waiting time and risk for women, birthing people and babies. A telephone triage system was also a part of the PAU and although based within that unit, staff were allocated to work solely in this area.

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 with mental health concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Maternity

Staff shared key information to keep women safe when handing over their care to others. The patient care record was on a secure electronic patient record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used a SBAR tool (situation, background, assessment and recommendation) when carrying out patient transfers.

Shift changes and handovers included all necessary key information to keep women and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, recommendation for each patient.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff completed APGAR scores at 1, 5 and sometimes 10 minutes after birth. APGAR is a quick test performed on a baby to determine how well they are doing after being born. Staff also completed NEWS (Neonatal Early Warning Score), which is a traffic-light coded observation chart to enable early detection of adverse changes.

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

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. Staff completed Newborn and Infant Physical Examination (NIPE) assessments of newborn babies before they could be discharged.

Midwifery Staffing

The service usually had enough maternity staff. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staffing levels usually matched the planned numbers to keep women, birthing people and babies safe. On the day of inspection midwifery staffing numbers were at the planned level. Staff told us they usually had enough staff unless there was sudden sick leave. In those instances, managers looked at the acuity in the area and moved staff if needed to ensure staffing was safe.

The most recent assessment (January 2022) of the recommended safe staffing ratios for the maternity service compared favourably to BirthRate Plus working fulltime equivalent (WTE). The overall ratio was 37 births to 1 WTE midwife, which the trust stated they had been compliant with in their maternity staffing report to the trust board from 1 April to 30 September 2022. In October, November and December 2022, data showed there were no instances where there were 2 or more midwives short. Staffing meet acuity 86% of the time.

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. In October, November and December 2022 there were 17 red flag incidents. This resulted mostly in a delay between admission for induction of labour and beginning the process and was mostly due to unexpected midwife absence or being unable to fill vacant shifts, although redeployment of staff also contributed.

Maternity

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 81.06 whole-time equivalent (WTE) midwives Band 3 to 8 compared to the funded staffing of 80.91 WTE, a shortfall of less than one WTE staff member.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. From 1 April to 30 September 2022 the compliance rate reported for one-to-one care was 100%. Rosters for labour wards were planned to always allow for one supernumerary coordinator. The trust reported there had been 21 occasions during the same months when red flags were raised to show supernumerary status had not been maintained, however on further investigation these had recorded expected tasks within the supernumerary role. Since September 2022 the monthly maternity dashboards showed red flags had been raised once or twice a month in regard to supernumerary status.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women. However, they reported any concerns to senior managers who were able to move staff according to the number of women in clinical areas.

The service had high sickness rates. The service's midwifery Staffing Report to Board identified the service had a sickness rate of 7.9%, which was a reduction on the average of 11% between September 2021 and April 2022. This was a combination of long and short term sickness and COVID related absences. Senior managers had looked at reasons for this and developed some actions to try to reduce further the number of staff absences, including personalised contact from specific staff to support those who were struggling.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service.

The service made sure staff were competent for their roles. The service had a practice development midwife team who made sure all staff received the training needed to carry out their roles. This included supporting and encouraging band 2 support workers to successfully complete an apprenticeship to become maternity support workers (MSW) and promotion to band 3 level. The benefits of providing this support was a more satisfied and motivated workforce and in turn a reduction in staff turnover, greater consistency and safety, and safe delegation of tasks by midwives.

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. Staff were supported with career progression through personal development plans and could access a continuous professional development fund to help with this. Midwifery staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Appraisal rates for midwives, however at almost 73.5%, these were below the trust's target of 85%. The service senior managers and practice development midwives told us appraisals for all staff who were out of date had been scheduled.

Medical staffing

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

Maternity

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. Staff said the service usually had enough medical staff to keep women and babies safe on labour ward. The consultant onsite cover was from Monday to Friday 8am to 8pm, 7 days a week (84 hours cover per week). There was a consultant rota for on-call cover for all acute maternity areas, including PAU, the ante and postnatal ward, and labour ward, between 8pm and 8am. The consultants had remote access to patient records and all lived within half hour travel of the hospital. The rota ensured that consultants were present and available for direct or indirect supervision.

The service had recruited another 2 consultants and had plans to advertise for a further 2 consultants to ensure there were enough surgeons to cover emergency complex gynaecology surgery.

We saw there were adequate numbers of medical staff available on the day of our visit to ensure areas such as the PAU and the birthing centre had medical cover when required. Midwives in the PAU told us medical staff met national guidance for women and birthing people to be seen and audits showed this was 92%. However, the service's risk register showed there were gaps in the senior house officer (SHO) rota. The service had recruited another trust doctor to support the SHO rota.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The consultants ensured an on-call rota for junior doctors was completed for each shift. As well as a consultant on-call each day, there was also a registrar and a SHO level doctor on the on-call rota. There were a total of 11 registrar level doctors and 9 GP trainee/SHO level doctors employed. Dedicated anaesthetic consultant and junior doctors were available 24 hours a day to cover elective and emergency caesarean sections or other surgical work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Appraisal rates for consultants and junior medical staff however, were at almost 67% which was below the trust's target of 85%. The service senior managers and practice development midwives told us appraisals for all staff who were out of date had been scheduled.

Records

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

Women and birthing people's notes were comprehensive and all staff could access them easily. The trust used an electronic records system. We reviewed 8 paper records and found these were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. This was because the electronic records system linked to other trusts using the same system. All neighbouring trusts with shared activity used the same electronic system for maternity services.

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

The trust had a digital midwife who was able to support the leadership and governance team when running reports and audits on the data stored in the electronic system. Staff were also supported and provided with training in order to

accurately use the system. The service had also established a maternity IT board to ensure there was continuous digital improvement by identifying strategic priorities and monitoring risk in the IT systems. Two midwives were trained as clinical safety officers to help monitor potential hazards. The service produced a strategy and infographic to help keep staff informed of their digital goals.

Women and birthing people acceded their own electronic records using an online or mobile app. If a woman or birthing person did not have access to an electronic device staff could print records for them.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The trust had introduced an electronic medicine dispensing system, which worked on secure login from individual staff members. Midwives new to the trust and those working in the trust's preceptorship programme received mandatory training in medicine management as part of their training programme. They received checks to assess their competency to carry out medicine management tasks.

Women had prescription charts for medicines that needed to be administered during their admission. We reviewed 6 prescription charts and found staff had correctly completed them.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the medicine records we checked.

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

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

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

Staff learned from safety alerts and incidents to improve practice.

Incidents

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

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events on any wards, although there were 2 never events in theatre shortly prior to our inspection visit. Information provided by the trust showed appropriate action was taken to identify possible causes, actions to reduce the risk of reoccurrence and how new training was to be escalated to staff.

Managers reviewed incidents on a regular basis to identify potential immediate actions. Managers were aware of the criteria for reporting incidents to the Healthcare Safety Inspection Branch (HSIB) for investigation and that incidents, such as stillbirth or neonatal death required a 72 hour review.

Matrons, senior midwives and obstetricians were amongst staff who reviewed incidents involving fetal deaths to identify whether care they received contributed. The completed report was then shared with the woman or birthing person and included advice and recommendations for further pregnancies and staff supporting them.

Managers shared learning with staff about never events that happened elsewhere. The service had several ways in which they shared learning from incidents with staff. For example, staff involved in incidents received a hot debrief shortly after the incident. This provided staff with the opportunity for immediate learning. Staff received emails about incidents that occurred in maternity in theirs and other services, actions the trust had taken to address these and actions staff needed to take to reduce any reoccurrence. Information was also displayed on staff noticeboards and discussed at staff handovers.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at an obstetric clinical governance meeting in January 2023. Leaders reminded staff of the importance of adequately reviewing case notes in regard to electronic incident reporting and the need to follow local and national guidelines during ultrasound. One midwife told us the outcome and actions from electronic incident reports were always fed back to staff. Staff had an open invite to risk management meetings and were encouraged to attend. Staff also received information through the service's monthly newsletter, Risky Business, which provided updates on upcoming meetings, key learning, electronic incident reporting, changes to guidelines and policies, and feedback from women and birthing people.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Governance reports and reviews of incidents included details of the involvement of women and their families in investigations and monitoring of how duty of candour had been completed.

There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following incidents.

Managers debriefed and supported staff after any serious incident. Staff told us that managers spoke to and supported them after any serious incident. Governance meeting minutes also recorded where ongoing or further debrief of staff was required following reviews of incidents.

Maternity

Is the service well-led?

Good 

We rated Well-Led as good.

Leadership

Leaders had the skills and abilities to run the service, they were compassionate, inclusive and this lead to effective leadership at all levels. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They had a deeply embedded system of support for staff to develop their skills, take on more senior roles and work in the best way possible for the benefit of women, birthing people and babies.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Maternity services were managed as part of the surgical division. The trust had a clearly defined management and leadership structure. Maternity services were led by a triumvirate, consisting of the Head of Midwifery (HoM), General Manager, and Clinical Director. The HoM was supported by 4 matrons with different responsibilities, a public health midwife and Professional Midwifery Advocates. This team worked together, with the rest of the trust and external agencies and bodies to maximise care provision for women and babies.

In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. Maternity performance indicators formed part of the trust's integrated performance report to the board. The HoM attended board meetings and presented any midwifery papers/reports. This included updates on national reports, such as 'Reading the Signals; Maternity and Neonatal Services in East Kent', actions the trust needed to take to achieve the recommendations and progress with these actions. Parents stories were also presented to help the board understand their lived experience. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies.

They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them, which were shared with staff.

Leaders were visible and approachable in the service for women and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons, who they all saw on a daily basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were. All staff knew the HoM and spoke with them confidently during our visit, the HoM in turn addressed every staff member by name. The HoM and other senior midwives and managers also visited community services to check in with them.

The service was supported by a maternity safety champion and non-executive director. The leadership team prioritised the safety of their maternity service. The trust had a board level maternity safety champion who met every other month with the HoM and other triumvirate members regarding maternity services. They completed regular walk-arounds, scrutinised data and maternity reports. They were knowledgeable about the service and proactive about holding the leadership team to account.

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

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Strategies and plans were aligned with plans in the wider health economy, and there was a commitment to system-wide collaboration and leadership.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The maternity service's current 5 year vision and strategy ends this year, having achieved its mission to transform services with regard to implementing the 'Better Births' vision for maternity care. The Better Births vision was for services to "become safer, more personalised, kinder, professional and more family friendly' and for women and birthing people to have access to information, support based on their individual needs. It also focussed on staff being supported to be women and birthing people centred, deliver high quality care and develop a culture of learning and good multidisciplinary working. We saw during our visit, that this had been achieved.

In developing their next vision and strategy for maternity services, senior managers told us that as well as including recommendations from national reports, such as Ockenden, 2020 and 2022, and East Kent, they planned to focus on equity and equality. They planned to involve women, birthing people and staff to ensure they provided safer care in a personalised way that adds value and listens to local communities. It was clear the maternity leadership were passionate about their new strategy and that it was developed in a way that engaged with different communities to provide a service they would be happy to engage with.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service's 5 year vision was to ensure high performing teams with effective multi-professional team working.

Leaders and staff understood and knew how to apply them and monitor progress.

Culture

Staff felt respected, supported, and valued, and there were high levels of staff satisfaction. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. Staff had excellent working relationships with their peers and other staff groups within the service. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued; there were high levels of staff satisfaction across all staff groups. Staff we met during our visit were welcoming, friendly and helpful. They displayed an overwhelming sense of being happy at work and all staff we saw were smiling. We spoke with staff across most grades and disciplines, who all told us they were proud to work for the trust. They said they felt valued as a staff member and were respected by the management team. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

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The culture of the service was one of learning and focused on improvement, not blame. Leaders led by example and acknowledged that their behaviour flowed through the service. This meant meetings were considerate and encouraged openness and honesty to promote learning and provide assurance that learning was embedded. Staff spoke positively about the collaborative working and supportive relationships between different staff groups. They had opportunities to learn together and there was no hierarchy amongst the different teams.

Staff were focused on the needs of women receiving care. Staff worked within and promoted a culture that placed patient care at the heart of the service and recognised the power of caring relationships between people. Most women and birthing people we spoke with and survey responses told us staff were “amazing”, midwives were “empowering”, “fabulous” and “caring”. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

The 2022 NHS Maternity Survey showed that the service achieved “better than expected” results compared with results for 2021. The survey scored questions relating to experience of care they receive across their entire maternity journey.

Leaders understood how health inequalities affected treatment and outcomes for women and babies from ethnic minority and disadvantaged groups in their local population. The service introduced a maternity and neonatal equity and equality steering group developed from the ethnic minorities steering group. Work from this group included initiatives through the ‘Best Start in Life’ (BSiL) team to support women and birthing people, such as enabling access to emergency food boxes for vulnerable families, providing weekly outreach clinics in family hubs to promote the uptake of vaccinations. Midwives who identified vulnerable women and birthing people at any point during their pregnancy could refer for this support. In 2021 NHS England mandated maternity services to implement actions to reduce risks to ethnic minority women and birthing people. The service took the action to introduce free access to healthy start vitamins, including vitamin D, to encourage this.

They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. The service supported the MVP by getting feedback cards produced in the 5 most spoken languages, apart from English, so they could be used when the MVP engaged with ethnic communities. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care. Staff had developed a poster about equality and diversity that was a finalist at the Better Births Conference.

The service promoted equality and diversity in daily work. The maternity voices partnership engaged with women and birthing people who were potentially hard to reach by arranging meetings in venues more suitable to them, such as at community groups. The outcome of these meetings were shared with senior managers at meetings that also addressed equality and inclusion. The feedback had become a regular agenda item at maternity services and the maternity voices partnership meetings. Two areas that had been fed back were about ‘skin to skin’ opportunity immediately after delivery that occurred in theatre and women and birthing people’s experiences of the third stage of labour. Further training had been arranged for staff and ‘Third Stage’ was scheduled to be theme of the month in the maternity department. The HoM had published an action plan that addressed issues about skin to skin following delivery.

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

The service had an open culture where women, birthing people, their families and staff could raise concerns without fear. The trust had a Freedom to Speak Up team that provided staff with a safe place to raise concerns. The trust won the

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Freedom to Speak Up Organisation of the Year in the Health Service Journal Awards in 2021. The award citation included, “The passion and hard work of the Freedom to Speak Up Guardian shone through and was brought together with well-established processes, networks, and support that enabled the organisation to demonstrate that speaking up is at the heart of everything it does.”

Project Joy was developed in response to a Royal College of Midwives survey that identified more than 50% of midwives had considered leaving the NHS. The service secured funding from NHS England to develop Project Joy for staff wellbeing following the COVID-19 pandemic to say thank you to maternity staff. After consultation with the Staff Wellbeing Team and evidence in relation to staff wellbeing a proposal was agreed and the project launched in May 2022. Staff were encouraged to submit ideas about what would make their working lives better and the project sought to make the ideas happen. It has a committee represented by a cross section of the workforce to ensure staff health and wellbeing is supported and remained central to the service. All of the staff we spoke with knew about Project Joy and the impact it had on staff wellbeing. However, as well improving staff wellbeing it also had a positive impact on cohesive working and mutual respect.

Examples of changes as a result of the project included improvements to the staff break room on the antenatal and postnatal ward. This provided staff with access to a relaxing and comfortable area to sit and eat or drink. Staff were also able to decide how they took their breaks on long shifts and had the ability to take a longer one-hour break. This ensured staff could make the most of their break to relax and take their time eating. Shift patterns were reviewed as it was identified that some staff struggled with long shifts and the length of time between a long shift and another shift. One area was piloting a self-rostering system, which was working well and had helped with staff retention.

Trips to promote how well staff knew each other and give them the opportunity to get to know each other were arranged. All maternity staff were invited, with their families, to bus trips to York, Edinburgh and future trips to a theme park and a summer BBQ or beach trip. Support for staff physical wellbeing had wide ranging ideas, which included health and fitness trainers, walking and running groups, yoga sessions and discounted spa sessions. However, the project also recognised that the cost of living crisis had affected some staff and arranged a contract with local grocers for those staff that could benefit from this.

In 2021 the trust was awarded the highest level of ‘Maintaining Excellence’ of the Better Health at Work Award, a regional scheme that recognised workplaces’ efforts to improve staff health and wellbeing. The 2022 NHS staff survey showed the trust staff thought their trust performed highly when compared with other trusts’ staff opinions, with the trust scoring highest in staff satisfaction questions nationally. In questions about leaving their current job and where their next employment destination would be, most staff said they would prefer to stay in the organisation. Those saying they were not considering leaving was higher than the national average. The trust staff response rate to the survey was higher than the national average and scored the highest nationally.

Women, birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff so that learning was used to improve the service. This was a fixed agenda item on Obstetrics and Gynaecology Operational Governance Board (OGGB) meetings and each regular team meeting, at ward level, at multi-disciplinary meetings such as handovers, and was highlighted on staff noticeboards. Staff gave examples of how they used women's feedback to improve daily

practice. The service undertook a thematic analysis of closed complaints, which identified communication as the most common theme at 78%, an increase of 14% from the previous 12 months. The analysis was shared with staff through the 'Risky Business' newsletter and at ward level meetings. The service also made communication theme of the month in September 2022 and shared the analysis with all maternity staff.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. This included when complaints had been resolved at a local level and ensured women and birthing people were given a written record of the investigation and outcome of their complaint.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The trust worked with external agencies to ensure compliance with national reports and incentives, such as the NHS Resolution Maternity Incentive Scheme (MIS). In April 2023 the trust received notification that maternity services were successful in achieving compliance in all 10 safety standards for the MIS.

Maternity services were on track with all measures outlined within the year-4 MIS and held regular meetings to discuss other areas, such as fetal and neonatal mortality reviews. Parental views and feedback were included for all cases and questions that parents had regarding care were included in the review to ensure they received timely and full feedback.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. Groups and meetings, such as Perinatal Mortality Review Group and the Maternity Incident Review Group, fed information straight to the Obstetrics and Gynaecology Governance Board (OGGB), which was the main governance meeting for the maternity service. The OGGB then fed information to the trust board either via the Trust wide Assurance Committee or the Surgical Integrated Governance Group and Clinical Policy Group. The HoM was responsible for leading on and reporting on this and other national outcomes to these agencies and to the trust board; they acted as an intermediary to keep staff and others updated.

The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. The OGGB was chaired by the HoM and attended by other senior staff, such as the Business Unit Director, the Maternity Safety Champion (Non-Executive Director) and the General Manager, as well as consultants, matrons, ward managers, specialist midwives, the MVP chair and other health care professionals. We reviewed 3 OGGB meeting minutes, which showed the meetings were well attended by a variety of staff. Meetings had standing agenda items to ensure regularly updates were received on incidents, complaints, risks, clinical guidelines, performance, staffing and updates in relation to national reports. Minutes also included actions that had been decided at the meeting and the staff member who was responsible for responding to these.

An audit plan had been developed to continually monitor and identify areas to improve outcomes for women and birthing people. Maternity services participated in both national and local audits, including the National Maternity and Perinatal Audit. This looked at statistical information about birth, such as the number of caesarean sections performed, whether an episiotomy (deliberate cut to avoid a tear during birth) was performed or the number of women and birthing people who had given up smoking while pregnant. This showed the hospital statistics overall were in the median range, neither significantly lower or higher than national averages.

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Local audits included compliance with World Health Organisation theatre checklists, the use of antenatal electronic monitoring for reduced fetal movements and the involvement of women and birthing people in decision making about induction of labour. Each audit had a lead midwife or health professional, start and planned finish dates and a priority risk.

The Emergency Surgery and Elective Care Business Unit director had overall responsibility for clinical audits and the business unit identified leads for national audits and their specific responsibilities. The Surgery Integrated Governance Group (SIGG) met monthly with attendance by clinical audit leads every 2 months. The audit lead for maternity was the Clinical Director for Obstetrics, who was a consultant obstetrician.

Learning from incidents and Healthcare Safety Investigation Branch (HSIB) recommendations were shared across the service. The Board was updated on a monthly basis about all maternity and neonatal serious incidents and incidents graded as moderate harm or above. The findings of incident reviews and investigations were discussed at the OGGB (the main governance meeting for the maternity service) and staff from all levels of the service were encouraged to attend these.

The service also took action when organisations, such as the HSIB put out guidance nationally. In 2021 the HSIB identified an increased risk to babies due to the different number of fetal monitoring machines in use, the difficult this posed for staff in relation to adequate training to use the different models and compatibility with existing equipment. The service obtained funding to ensure they were able to procure the same machines for the whole service, which ensured compatibility with the trustwide electronic system and allowed immediate oversight of fetal monitoring wherever that took place in the hospital. All staff received training, not just on interpreting a reading but also on use of the machine.

Staff received information about policies and guidance that were identified as needing review by email. They were asked to submit comments before the review completed and to read the document once it had been reviewed. This enabled staff to contribute to the documents that shaped how they worked.

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

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

Management of risk, issues and performance

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

The service participated in relevant national clinical audits. As well as taking part in the National Maternity and Perinatal Audit, the service also participated in 3 other national audits: the Maternal, Newborn and Infant Clinical Outcome Review Programme, the Smoking Cessation Audit Maternity and Mental Health Services, and the National Perinatal Mortality Review Tool. Outcomes for women were positive, consistent and met expectations, such as national standards.

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Data sent to us following our inspection visit showed the trust scored well in national clinical audits. Summary results from October 2022 for the Perinatal Mortality Review showed the trust performance was rated as 'Good Practice' and their risk was 'Low'. Perinatal, still birth and neonatal mortality rates had reduced by between 17 and 21%. Managers and staff used the results to improve women's outcomes.

The service monitored how many women and birthing people smoked at the start of their pregnancies and also at the birth of babies. The rate of smoking at time of delivery in 2019/2020 was over 12%, which was more than twice the national target of less than 6%. In response to further increases in 2022 to this the service implemented a pathway as part of their Best Start in Life (BSiL) programme to assist staff to encourage women and birthing people to stop smoking. The pathway quickly had a significant impact to reduce the number of women and birthing people still smoking at the time of birth. The service provided additional information following this inspection, which showed the number of women and birthing people still smoking at the time of birth had again reduced significantly to just over 3% (half of the national target). It also brought into place specific actions for staff to support women and birthing people to stop smoking, including referral for them and other household members to the Smoking Cessation Team. The pathway monitored effects of continued smoking on fetal growth and increased the number of scans women and birthing people received.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. Staff completed 30 local audits in the 12 months before this inspection, of which almost a half (14 out of 30) were re-audits. This ensured areas that had needed improvement were reassessed to check changes had the desired effect and whether a programme of ongoing improvement was needed to continue improvement. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

The trust had a Maternity Risk Management Strategy/Policy that provided clear guidance for staff on referring incidents, which staff were responsible for referring on to external organisations, and which staff were responsible for investigation and timeframes for this. The Business Unit Director had operational responsibility to ensure patient safety incident investigations were fair and equitable, the cause of harm was identified, and learning was disseminated across the organisation.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service maintained a risk register to identify and manage risks, which included a description of each risk, controls and mitigating actions in place. The register also showed how much the risk had reduced by. The service's highest risks were rated as moderate and were in relation to the inability to provide adequate psychology support for women and birthing people, and the inability to have a surgeon capable of completing complex gynaecology emergency surgery, such as a caesarean hysterectomy. To mitigate these risks in the short term the service identified surgeons that could be called upon if the need for complex gynaecology surgery was required. They submitted an urgent business case for additional obstetricians to fill this on-call shortfall and had recruited 2 and advertised for another 2. Changes were proposed to the obstetric on-call rota to ensure adequate cover once new consultants had started work.

Mitigation of the lack of clinical psychology staff included reducing some areas of availability to ensure women and birthing people who were referred were seen, engaging support from midwives and the wider psychology team and requesting funding for additional staff. At our inspection staff told us a new clinical psychologist had recently started work at the trust.

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Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk meeting. The leadership team took action to make changes where risks were identified. The service monitored the number of incidents and serious incidents that staff reported monthly. Governance and risk leads joined up with leads across the local maternity and neonatal system to identify learning from incidents across the system.

There were plans to cope with unexpected events. The service had escalation plans for the maternity service generally in relation to capacity and acuity issues, and specifically for different parts of the maternity service in relation to the safe care of women and birthing people.

Senior staff completed a virtual local maternity system meeting every day following the internal safety huddle, which was attended by staff from every maternity site within the trust, including community midwifery teams. They discussed risks across maternity service for the whole trust, including staffing, acuity, admissions and possible transfers. This made sure managers had oversight of all the risks that may impact the service, so they could take action to reduce and improve risks and outcomes for women and birthing people across a large geographical area.

Information Management

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

The service collected reliable data and analysed it**.** The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical KPIs. The trust had changed their recording system to an electronic system, also used by other trusts in the same area. This meant they could easily monitor their own performance and present it in a format that allowed easy comparison with other trusts locally.

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

Information from MBRRACE-UK and Public Health England identified a continued gap in the perinatal mortality rates for women and birthing people from a black, Asian or minority ethnic background. In response to this the service provided women and birthing people from minority ethnic backgrounds with an additional antenatal visit following their 22 week scan. This allowed staff to make sure the antenatal risk assessment was up to date and they were able to give further advice about the benefits of taking vitamin D, which was included in the free of charge healthy start vitamins. An equality and equity poster was developed to advise women about these risks and the actions the service was taking, which had also been produced in non-English languages. The trust's Public Health team also initiated a review of all recent serious incidents to understand if there was a relationship with minority ethnic women and birthing people and social deprivation that impacted on these perinatal mortality rates.

Staff told us they collected data to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes (to identify areas of social deprivation) and other risk factors such as, high body mass index, advanced maternal age and co-morbidities (other health conditions that increase risks to women and birthing people). This data was used in planning women's care and support and care records identified whether women were low or high risk as a result. This had allowed the service to target care towards one group of vulnerable women and birthing people from a deprived area that ensured they were given additional support and guidance on the effects of drug taking on the developing foetus.

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The information systems were integrated and secure**.** Electronic patient records and data kept by the service was all password protected and each staff member had to enter their own personal ID before accessing any records. Similarly, there was a process before staff could access patient records completed on the same electronic system at another trust.

Data or notifications were consistently submitted to external organisations as required. The service made sure they submitted information as required. Information provided to us following this inspection showed the service submitted information as required for national audits, in response to national reports, such as Ockenden, or to the Strategic Executive Information System (StEIS) or the National Reporting and Learning System (NRLS).

Engagement

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

The maternity service worked with the local Maternity Voices Partnership (MVP) to help make sure women's and birthing people's views were represented and maternity services were designed to meet local needs. They worked together to determine how accessible information was and what was needed to improve care and choice for all women and birthing people.

Maternity services and the MVP worked closely throughout the pandemic to inform women and birthing people about changes, keep them informed and reassured them they were there to support them. They worked together to update women and birthing people during the introduction of the service's record keeping system. The service worked to produce leaflets, posters and information to access electronic information, including QR codes that could easily be scanned so that women could obtain specific information.

The service collaborated with partner organisations to help improve services for women and birthing people. The service and MVP had also developed an Ethnic Minorities Steering Group to look at how they could more effectively engage with women and birthing people from these communities. They linked with one family hub successfully and were arranging to expand this work to other community groups. There were also plans for an externally funded post for a Best Start in Life (BSiL) advisor for ethnic minority women and birthing people.

Both the maternity service and the MVP used social media platforms to connect with and obtain the views of women and birthing people. They provided information directly and links to more detailed information, such as a recent journal article about induction of labour, a charity supporting parents after losing a baby or perinatal mental health. Staff told us having access to information and responses in this way had increased their ability to relay information and enabled women and birthing people to access in a way they were familiar with.

The service had systems to engage with staff. There were staff and student information boards in clinical areas that provided contact details for Freedom to Speak Up Guardians and others where staff could get support. They undertook a staff survey in January 2023, which showed an overall improvement from the previous survey in July 2022, although some aspects of staff morale remained low.

Senior managers made staff wellbeing a priority. Professional midwife advocates had included this in their role and developed a system to support staff who may be struggling by undertaking carer conversations. They worked with staff to identify issues, change working arrangements if needed and help each staff member to work through their difficulties by developing individual plans that suited individual needs. This initiative had retained 32 midwives.

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The service made available interpreting services for women and pregnant people and collected data on ethnicity. The trust used a telephone interpreting service when needed.

Leaders understood the needs of the local population. One of the service's identified priorities was in relation to the large geographical area the trust covered and the impact this had on women being able to access care and treatment in a timely way.

Learning, continuous improvement and innovation

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

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. They had a quality improvement standard operating procedure (SOP) and a well laid out process for initiating quality improvement initiatives. This was supported by a dedicated Innovation Director and clinical lead to support clinical innovation projects. Staff were encouraged to follow this process if they had concerns and ideas about how to resolve them.

In their SOP the service said, "It's about giving the people closest to problems affecting care quality the time, permission, skills and resources they need to solve them." Ward staff told us how one of their team had taken an idea through this process, which resulted in a presentation to the board and a change in working practice.

In 2022 the service won the Bright Ideas in Healthcare finals for their MDT Fetal Wellbeing Education Programme. This education programme combined an MDT approach and teams with a safe space to reflect on practice and learn other, more effective ways of working and result in better outcomes for women, birthing people and babies. The service had also developed a bespoke breast feeding and tongue tie pathway to improve women, birthing people and babies' experiences. This had helped to improve the start of breastfeeding and skin to skin rates in hospital. It had also prompted work on jaundice recognition in darker skin babies with staff training beginning at the time of our visit.

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

Outstanding practice

We found the following outstanding practice:

- Senior leaders created a leadership ethos that encouraged all staff participation in the running of the service, which enabled staff to find solutions to problems and change the way they worked.
- The service had a culture of deep respect between all levels of staff that translated into an openness and joy at being at work, making this the top trust for staff satisfaction regionally and one of the top nationally.
- Senior leaders created Project Joy as a thank you to staff to show how much they appreciated their work and dedication.

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- Staff engagement with equality and diversity resulted in a poster for maternity services, Maternity Voice Partnership feedback cards in different language formats.
- Senior leaders had an excellent relationship with the Maternity Voices Partnership and supported them to engage as fully as possible with vulnerable women and birthing people, so that their voices were heard.
- In 2022 the service won the Bright Ideas in Healthcare finals for their MDT Fetal Wellbeing Education Programme.
- An initiative was started to support women and birthing people to give their babies the 'Best Start in Life' by providing emergency food boxes to vulnerable families, free healthy start vitamins, including vitamin D, and weekly clinics close to family homes to promote the uptake of vaccinations.

Areas for improvement

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 SHOULD take to improve:

Northumbria Specialist Emergency Care Hospital/maternity

- The service should continue to consider alternative bereavement room location at every opportunity.
- The service should continue to review on call consultant surgeon cover for emergency complex gynaecology procedures to ensure adequate cover is maintained.
- The service should continue to encourage all staff to complete an annual appraisal.

Our inspection team

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