Kettering General Hospital NHS Foundation Trust

Kettering General Hospital

Inspection report

Rothwell Road
Kettering
NN16 8UZ
Tel: 01536492000
www.kgh.nhs.uk

Date of inspection visit: 11 October 2023
Date of publication: 07/03/2024

Ratings

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

Our findings

Overall summary of services at Kettering General Hospital

Requires Improvement 

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

We inspected the maternity service at Kettering General 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 Kettering General Hospital provides maternity services to the population of Kettering and the surrounding areas.

Maternity services include an early pregnancy unit, outpatient department, maternity assessment unit known as the Fetal Health Unit, antenatal and postnatal ward (Rowan), Delivery Suite incorporating an assessment bay, triage bay and an enhanced care area, 2 maternity theatres, and an ultrasound department. The service had previously had a midwifery led birthing centre, although this was closed at the time of our inspection and had been for some time. Between April 2021 to March 2022 there were 3,275 deliveries at Kettering General 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.

We last inspected the maternity service in February 2019 and rated it as good. At this inspection we rated safe and well led only. We rated both safe and well-led as Requires Improvement.

Our rating of this hospital is Requires Improvement because our rating of Requires Improvement for maternity services did not change the ratings for the hospital overall.

How we carried out the inspection

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

We visited maternity assessment (Fetal Health) Unit, delivery suite including triage, and the maternity theatres, and the antenatal and postnatal wards. The midwifery led birthing centre rooms were closed during the inspection.

We spoke with 18 midwives, 4 support workers, 9 women and birthing people and 3 birthing partners and or relatives. We received 6 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 9 patient care records, 5 observation and escalation charts and 7 medicines records.

Our findings

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

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

Maternity

Requires Improvement ↓

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not always complete all safeguarding records fully or in a timely way.
- Staff did not always use equipment and control measures to protect women and birthing people, themselves, and others from infection. The service did not always manage cleanliness and control infection risk well or keep all equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment did not always meet requirements to keep people safe. Staff did not always complete all checks on emergency equipment.
- Staff did not always follow triage processes to complete and update risk assessments.
- Staffing levels for midwives did not always match the planned numbers, putting the safety of women and birthing people and babies at risk. There were insufficient suitably qualified and competent medical staff for maternity triage and elective caesarean section lists. Some women and birthing people experienced delays in care.
- Staff did not always ensure correct patient identification information was always used. There were differences throughout the service in types of medical records used, and staff access to them. This posed a risk to inconsistency and availability of necessary and up to date information.
- Staff did not always store medicines safely.
- Managers did not always ensure that actions arising from action plans were monitored and closed. Leaders did not always understand and manage the priorities and issues the service faced. There were different management styles and methods across wards, and leaders were not always aware of staff concerns, safety, environment, or cleanliness levels across the whole department. Leaders did not always operate effective governance processes.
- Not all staff felt respected, supported, and valued. A small number of staff spoke about difficulties with communication between teams and inconsistencies in management, and there had been some instances of discrimination.
- The service did not always ensure duty of candour was carried out in a timely way.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect women and birthing people from abuse.
- Staff kept detailed records of women and birthing people's care and treatment. Records were clear and stored securely. Staff took action to remove or minimise known risks. Staff quickly acted upon women and birthing people at risk of deterioration.
- To support in times of risks relating to staff shortages in the service, a midwifery manager on call system was in place 24 hours a day, 7 days a week.
- There was enough anaesthetic cover to support the service with dedicated consultants and additional on-call cover provided by a middle grade anaesthetist.
- The service used systems and processes to safely prescribe, administer, and record medicines.

Maternity

- The service investigated incidents and shared lessons learned. When things went wrong, staff apologised and provided honest information and suitable support and implemented action plans.
- Leaders generally had the skills and abilities to run the service and were visible and approachable. They supported staff to develop their skills and take on more senior roles.
- The service was focused on the needs of women and birthing people receiving care. They provided staff with opportunities for career development. The service had a culture where people and staff could raise concerns without fear.
- Staff were clear about their roles and accountabilities. The service collected reliable data, used, and analysed it. Information systems were secure. Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- Leaders and staff actively and openly engaged with local people and staff to plan and manage services. They collaborated with partner organisations to help improve services.
- The service had a joint vision and strategy developed with a neighbouring service. 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.

Is the service safe?

Requires Improvement 

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

Mandatory training

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

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

Nursing and midwifery staff received and kept up to date with their mandatory training. Ninety-three per cent of registered nursing and midwifery staff had completed all 10 mandatory training courses against a trust target of 85%.

Eighty-six per cent of midwifery staff had completed basic life support training and 96% had completed newborn life support. The service provided a CTG training day which included a bespoke competency test, and 93% of midwives had completed this. Ninety-six percent had completed perinatal mental health training.

Medical staff received and kept up to date with their mandatory training. Ninety per cent of staff had completed all mandatory training courses. The compliance rate for CTG training, including the competency test for doctors was 89%. Ninety per cent had completed perinatal mental health training.

Eighty-five per cent of medical staff had completed basic life support, and 84% had completed newborn life support (NLS). The trust told us that further NLS training courses were planned with medical staff booked to attend in November and December 2023, which would increase compliance to meet the trust target.

The service made sure staff received multi-professional simulated obstetric emergency training. The compliance rate for doctors was 90% and midwives 94%.

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.

Safeguarding

Staff understood how to protect women and birthing people 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. However, staff did not always complete all safeguarding records fully or in a timely way.

Staff received training specific for their role on how to recognise and report abuse. Training records showed 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. Midwives and nurses had achieved 95% compliance for Safeguarding adults' level 3 and 93% for safeguarding children level 3. Medical staff had achieved 100% compliance for Safeguarding adults' level 3 and 85% for safeguarding children level 3. These rates met the trust target of 85%.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team. The maternity service was part of the Northamptonshire Safeguarding Partnership (NSCP) and had formed a pre-birth pathway. This identified and assessed families in need of additional support or where there were safeguarding concerns, and provided a coordinated response by local agencies to ensure appropriate support was in place. The service provided this through a team of midwives on the Sapphire team who held caseloads of women, birthing people and their families and provided individualised perinatal care.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures. The service monitored cases where staff had identified female genital mutilation (FGM) and reported these monthly to national statistics data collection. The service worked with NSCP regarding high-risk cases including FGM. The team followed up referrals and provided updates to staff and to the board.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. We saw posters in the department and staff explained the baby abduction policy. we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection. The service provided label tags for babies.

Ward clerks worked day shifts from 7am to 7pm and monitored the ward entrances and exits. Midwifery staff answered calls for access when ward clerks were off duty. There was an intercom system to gain access to the wards and staff controlled the exit doors.

We found incident records showing staff had not reported a case involving inappropriate or unsafe behaviours displayed by birthing people or their partners overnight. Day shift staff had taken the required action. This was against trust policy which stated staff witnessing an incident must report it and not leave information to be input by a member of the team who had not been present at the time. We also found information in a mother's medical record to show a baby was on a child protection plan, yet there was no alert on the baby's record. If the baby were to be admitted onto another ward, there would be no indication of social care involvement, and staff may not have been aware the child had a protection plan.

Cleanliness, infection control and hygiene

The service did not always manage cleanliness and control infection risk well. They kept equipment and the premises visibly clean in most areas. However, staff on Rowan Ward did not always use equipment and control measures to protect women and birthing people, themselves, and others from infection. Staff duplicated some equipment checks, using electronic and paper recording methods, and it was not always clear which method was up to date.

Maternity service areas had suitable furnishings, and, in most areas, these were clean and well-maintained.

Managers had employed an additional healthcare assistant (HCA) on Delivery Suite to carry out equipment checks. We found staff had labelled all equipment with "I am Clean" labels and equipment on Delivery Suite was visibly clean. Cleaning records on Delivery Suite were up-to-date and demonstrated all areas were cleaned regularly.

Ward managers monitored cleanliness and infection control through monthly audits. Staff told us the trust Infection Prevention and Control (IPC) team carried out regular walkarounds. There was information on wards to show which staff had IPC lead roles.

The service provided a booklet outside each bay or single room with cleaning checklists, but these were not always completed. Domestic staff used a tick and sign board to show the floors, sinks, bins and surfaces had been cleaned. They explained they did not complete any formal checklists but said they worked alongside the HCAs who completed the clinical cleaning. This did not provide assurance all areas were cleaned appropriately.

Staff used an electronic equipment check system, accessed using a QR code, to log equipment checks in each area of the service. Therefore, there was more than one method used to document cleaning and equipment checks. Staff we spoke with during the inspection were not sure which method was up to date. Following the inspection, the service commented both methods were "valid tools providing an additional layer of assurance whilst the electronic system was being embedded."

On Rowan Ward there were no room cleaning checklists. Staff used a diary to document what cleaning they had done. There was a book outside each bay, but these were not completed, so the service could not be assured cleaning had taken place, or when.

A fridge in the day room was for use by patients but there were no records of temperature checks. We found packs of half empty formula milk stored in the fridge without labels, so people, their families, and staff would not know who it belonged to or how long it had been there. Some food items were out of date and some items were labelled for people who were no longer on the ward. We found there were several gaps in cleaning record books showing from April to August 2023 there had been between 6 and 15 days each month when cleaning and equipment checks had not been documented, which is not enough to ensure proper infection prevention and control. On Rowan Ward we found dirty equipment. One of the bathrooms had a stained shower seat, dirty fixtures in the shower, and debris left behind following refurbishment work. We also found spare equipment stacked against the wall in a clinical area, which posed a risk of injury and infection.

There were call bells at the sides of beds. All chairs and furniture were non-porous and wipeable. Curtains around beds were disposable and all in date, domestics changed these every 6 months or if they became dirty.

In trust audits showed the service performed well for cleanliness. The service audited compliance throughout the maternity areas and general average monthly compliance rates were 100%. Only one result provided for the 3 months before the inspection fell short of the trust target. This was for the “100 steps” audit in August 2023 where the score was 90% for Delivery Suite while Rowan Ward scored 97%. The audit sheets did not include actions or timeframes for improvements.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. The service provided audit information which showed staff met hand hygiene compliance with a score of 100%. Although uniform scores were slightly lower at 97% and 99%, these were good scores overall. During the inspection, we noted one midwife was wearing nail varnish on duty. This was contrary to hand hygiene requirements for clinical staff and the trust uniform policy. This had not been identified in any audits and does not meet NHS England and NHS Improvement “Uniforms and workwear: guidance for NHS employers” which states staff working in clinical areas should have clean, short, unvarnished fingernails.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always meet requirements to keep people safe. Staff managed clinical waste well.

We found the maternity service was located in an old building, windows were single glazed and in poor condition, bathrooms were in poor condition. Ward areas had not been refurbished to the latest national standards and some areas contained asbestos. There were warning signs in areas of Rowan Ward due to the presence of asbestos. The maternity service and estates department were aware of the presence of asbestos and risks were logged in the risk register about replacement of waste pipes, decorating and other works that mentioned asbestos. It was not clear what further risks had been caused because of its presence or how these would be managed and people kept safe in the existing premises.

Maternity

The Delivery Suite had 8 available delivery rooms, 2 theatres and a recovery area shared with the gynaecology service. National recommendations state the theatre recovery area should be designated for maternity patients only. On Delivery Suite there was a 4-bedded midwifery triage bay and a separate 2-bedded assessment bay. The Delivery Suite also had a t2-bedded high dependency observation bay for women who needed higher levels of care and observation than those provided on the general maternity ward. There were 2 birthing pools, but 1 of these was not available for use at the time of the inspection. The pool was in a room that was closed, waiting for estates work on repairs to be completed following a leak from the floor above. Staff did not know how long this room would be unavailable for use. This meant there was only 1 birthing pool available for use in the department.

Rowan Ward had 33 beds in 4-bedded bays and 3 single rooms, 1 of which was set aside for women and birthing people undergoing induction of labour. One of the single rooms had an ensuite bathroom with a bath. The other 2 single rooms had access to bathrooms on the corridor. There was a bay set aside for carrying out Newborn and Infant Physical Examination (NIPE) checks. There were 2 bays for babies requiring transitional care (TC). Midwives provided TC for mothers and babies, and neonatal nurses provided intravenous antibiotics but only if there was another midwife available to complete the second check. This meant most babies went to special care baby unit (SCBU) for their antibiotics.

The bereavement suite was in use during our inspection. It was located on Delivery Suite, but it was situated in an area away from most delivery rooms and had an alternative door that families could use to enter and exit without going through Delivery Suite, which met national recommendations. Families requested access and exit via an intercom so staff could ensure ward security. The Snowdrop Garden was accessed via the Bereavement Suite within a private courtyard garden area between ward buildings. It provided a peaceful area of remembrance for families experiencing a compassionate induction or whose babies had been stillborn or lost soon after birth. For protection and consideration for all concerned the windows facing the courtyard along an adjoining corridor were blanked out, providing additional seclusion and privacy.

There was a fetal health unit where antenatal day assessments were carried out. This included a waiting area shared with the neighbouring gynaecology assessment area, which did not meet current national recommendations. There was a 3-bedded assessment bay and quiet room, furnished in a very homely and non-clinical way. This room was also used by the maternity bereavement team.

The design of the environment did not always follow national guidance. Old shower fixtures, no longer in use, remained in place alongside new ones and there was a visible build-up of limescale which prevented proper cleaning. Maintenance debris had been left on a windowsill, and poor workmanship was seen on new fixtures. Shower chairs were broken and stained. In 1bay on Rowan Ward there was a temporary stainless steel sink unit. This contained a very small sink and was not labelled to show the water was not suitable for drinking. Staff explained the lack of usable equipment in some patient areas had an impact on their ability to provide safe and timely care.

The service had a contract for legionella testing of the water supply. A sink on Rowan Ward had recently been condemned due to cracked waste pipes and a temporary sink was installed. The service risk register stated there was an IPC risk because the sink did not provide adequate hand washing facilities for people or their families. It stated the estates team would “visit on a daily basis to remove waste and hand wash water from the portable sinks. Any spillages are mopped up and wet floor signs are used and staff and visitors are aware of the risk”. We found no signs or information for visitors regarding use of the temporary sinks.

Staff told us asbestos in walls had prevented or caused long delays in remedial works when needed. One room on the Delivery Suite was barred and awaiting repairs following asbestos removal.

Maternity

The risk register stated “Due to asbestos risk to staff, patients and visitors, works require forward planning and will impact on bed space available on the ward”, and “Asbestos needs to be removed to enable waste pipework to be replaced and then the bays need to put back together, decorated”. This action was due to be completed by 31 March 2024.

Staff did not always carry out daily safety checks of specialist equipment. On Rowan Ward we found resuscitaire and emergency equipment checks were not always completed. A resuscitaire was overstocked which could lead to confusion and delays in an emergency, and staff could not explain what consumables should have been stocked there.

On Delivery Suite, records showed resuscitation equipment was checked daily. The monthly resuscitaire checklists showed staff checked 100% of resuscitaires at every shift but this process could not provide assurance because staff had no guide on what to check for. Following our inspection, the service provided evidence to show resuscitaire stock checks had been standardised, dates checked, and excess stock removed. Managers provided staff with checklists for use with all resuscitaires throughout the department. All equipment had been checked and labelled with I am clean stickers, curtains had recently been replaced, trolleys were stocked, and contents were in date.

The maternity unit was fully secure with a monitored entry and exit system.

The service had suitable arrangements to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. On Rowan Ward partners could visit between 8am and 8pm and from 3pm to 7.30pm with their own children plus up to 2 other visitors. Staff said overnight stays for partners were provided at the ward manager’s exception only. The ward had provided overnight stays for partners prior to COVID-19 but staff said this had not come back into practice.

There were day rooms for birthing people and their partners with refreshments, seating, fridges, drink making facilities and information posters on the walls. We found toast was left out, covered with paper towels, which was not ideal as it was not clear how it had been there and would be cold. Fridges provided on Rowan Ward for people to use had not been defrosted. There were 2 shopping trolleys stored in the day room. Staff told us these were provided for birthing people to transport their belongings between wards. There were shopping trolleys stored in the corridor outside the department for the same purpose.

The service did not always have enough suitable equipment to help them to safely care for women and birthing people and babies. During the inspection there were insufficient CTG machines on Rowan Ward. Staff told us there should have been 7 but we found only 2, which was not enough to ensure the safety of unborn babies. We informed managers who told us immediately following the inspection they had located 5 machines and that CTGs were moved around the department with women and birthing people and had not been returned to the ward in a timely way. The CTG lead midwife checked CTG machines were in working order, but we found there was insufficient assurance there would be enough machines available for use on the ward in times of need. Following the inspection, the service undertook an inventory of all CTG machines in the department, 5 were stored in a cupboard on Rowan Ward, and a further 3 were expected to be available on the ward but had gone with birthing people to Delivery Suite or were located elsewhere, providing a total of 8. Staff undertook a routine 8-weekly inventory, and the service were assured there would be sufficient equipment in the right place at the right time to provide safe care.

On Delivery Suite there were sufficient cardiotocograph machines and observation monitoring equipment. Staff told us managers were responsive when staff asked for equipment, for example doppler machines, and there was a new portable ultrasound scanner on Delivery Suite.

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

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.

Assessing and responding to risk

Staff did not always complete and update risk assessments, and there was no framework embedded to assess the risks to women and birthing people attending triage. Staff took action to remove or minimise known risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff did not always complete risk assessments for women and birthing people on arrival, using a recognised tool, or review this regularly, including after any incident.

We found there was no framework embedded to assess the risks to women and birthing people attending triage, and staff did not prioritise patients according to clinical need. Risks were assessed by midwives using their own experience and knowledge, which posed a risk that care may be inconsistent or not provided. We found there was no dedicated triage telephone line and anyone, including the ward clerk, may answer the phone. Staff told us a call would be transferred to a midwife for advice and decision making. Although a system had been introduced to record the time of arrival at triage of a woman or birthing person, we noted during the inspection staff did not always record arrival times for birthing people attending triage and did not always complete a record of the telephone triage conversation. This meant the service could not be assured women and birthing people were seen in a timely way according to best practice and could lead to errors and missed opportunities to provide safe care. Staff used the patient digital record for birthing people attending triage. This included recording of observations and staff transcribed any paper CTG trace into the electronic record. There was some difference in opinion between staff on how this happened and if or when information would be transcribed, which posed a risk that clinicians could not find relevant information when needed and opportunities were missed.

We shared our concerns with leaders and following the inspection they confirmed there was no standard operating procedure or guidance to assist midwives assessing women and birthing people who attend the triage assessment unit. The service responded to say they intended to devise a guideline for midwives to follow as part of a quality assurance project for triage, first discussed in a governance meeting in April 2023. Planning was due to begin in October 2023 and implementation to commence in December 2023. They stated “all non-planned care (triage) would be managed through Delivery Suite to ensure a streamlined process whilst a new standard operating procedure (SOP) or guideline was written”. A first draft of the SOP had been started as part of a quality improvement project and discussed at a triage meeting on 3 January 20224 but was not complete. They had implemented a project charter for the introduction of dedicated maternity triage with a system to “adhere to the Birmingham Symptom Specific Triage System (BSOTS) format and guidelines”. Leaders told us a new process had been introduced immediately. All calls to triage would be made through the 2 Delivery Suite phone lines. Therefore, although a ward clerk might answer the phone, any advice would be given by a midwife. The midwife taking the call would complete the birthing person’s electronic record with the time of the call, record the person’s experience, history and the outcome of their assessment. The birthing person’s time of arrival would be documented on the main patient administration system and their electronic record. Staff would report any incident as a red flag for any birthing people who waited longer than the recommended time period of 30 minutes via the trust’s electronic incident reporting system. There were no assurance measures at that stage.

Maternity

The service recorded the lack of a risk assessment and guideline as a moderate risk on the trust risk register following the inspection. The risk record stated assurances would be monitored via an annual audit, the maternity dashboard, any complaints received and incidents.

There was no clear way to measure if women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Although staff did not always record times of arrival for all people in triage, leaders said they monitored waiting times. The service undertook an annual audit of "triage seen times". The service provided the most recent audit for cases occurring in the first 2 weeks of August. Results demonstrated, through looking at patient records and the admission book for Delivery Suite, all birthing people were seen in triage within 30 minutes of arrival. The audit concluded the required standards were met and findings demonstrated no risk to patient safety with no patient safety incidents in relation to delays.

The service ran antenatal specialty clinics including fetal medicine and twin pregnancy clinics. They launched a Raised BMI clinic in August 2023. All women with a raised BMI above 30 would be invited to a 1-hour virtual education session with the health and wellbeing midwife. Referrals were sent from community teams and addressed risks associated with having a raised BMI in pregnancy, mitigating factors and health promotion.

We observed theatre cases and the whole team worked together to complete all parts of the World Health Organisation (WHO) safer surgical checklists. The service had a guideline to manage massive obstetric haemorrhage. This included preventative actions from effective antenatal screening, referral to fetal health clinic, advice to women and birthing people, and monitoring and managing antepartum and postpartum haemorrhages. However, we observed a case in theatre where the team did not announce a massive obstetric haemorrhage (MOH). Following the inspection the service provided information that there was clear documentation in the patient's notes, and the estimated blood loss had been recorded, which required the swabs to have been weighed. Obstetricians acknowledged this and said they would consider appointing a theatre lead to take charge of this in future.

Women and birthing people were given information on which department to attend by community midwives. There was a social media page with contact numbers and women and birthing people had a folder with contact details. People were directed to call the Delivery Suite and staff would transfer calls to the most appropriate area. Staff said the Fetal Health Unit was not a 24-hour service. It operated 7am to 7pm Monday to Friday and 8am to 4pm on Saturdays. When the Fetal Health Unit was closed, staff directed people to attend Delivery Suite. The Fetal Health Unit was a day assessment area, staffed by 2 midwives and an HCA. Staff provided between 10 and 15 planned appointments, day care, including CTG (regular monitoring), and iron infusions. They also took self-referrals from women and birthing people, and referrals from community midwives and antenatal clinics. The service provided a standard operating procedure (SOP) for fetal health staff to follow. Women and birthing people at full-term with spontaneous rupture of membranes (SROM) were also directed to attend. Staff did not see those with blood loss, contractions, pain, or signs of pre-term labour. Fetal health staff completed an outpatient assessment form, which outlined the reason for attendance. Staff explained recording these details helped to see how many times a person had attended with reduced fetal movements (RFM). They could find information regarding key risks using a search function on the electronic record.

The unit had 3 CTG machines, all of which used software to provide an analysis of the data. This meant staff viewed each machine's trace separately.

Maternity

Antenatal clinics provided screening, fetal health, fetal monitoring, and maternity immunizations. Obstetric consultants had oversight of all high-risk women and birthing people, and the local maternity tertiary centre provided support with fetal medicine clinics twice a week. There were 7 midwives trained to carry out 3rd trimester ultrasound scans. They provided a service 5 days a week. Urgent scans were carried out within 72 hours or 3 working days. Some consultants could undertake scans in an emergency. Early antenatal scans were provided by the trust scanning service.

Staff did not always complete a risk assessment at each CTG. Monthly audit showed compliance for this ranged from the highest score of 87% in May 2023 to the lowest at 49% in August 2023, which was not enough to assure the safety of unborn babies. Leaders had described compliance as “disappointing”. Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). Staff carried out monthly CTG and fresh eyes documentation audits. Results showed varied compliance, between 80 and 100%, for completion of care plans and hourly fresh eyes checks. In all months 100% of classifications had been correct. A care plan was completed to include intrapartum fetal monitoring and fresh eyes sticker reviews. Findings showed correct escalation of risk was documented.

Staff knew about and dealt with any specific risk issues. Staff logged in patient records any women and birthing people who did not attend (DNA) planned appointments including actions taken. They explained they would hand this information over to the Delivery Suite to action and follow up. Sometimes a community midwife would visit a pregnant woman if there were specific concerns, but this was rare.

The service referred complex cases to their local tertiary centre. They had developed pathways to ensure prompt joint cardiology reviews with guidelines for hypertension and diabetes. They managed patients with respiratory conditions in the maternal medicine clinic. Doctors explained this helped them identify any risk of fetal compromise and manage it accordingly.

Following the findings of the service’s most up to date Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) reports (2021 and 22), the service worked with the local maternity and neonatal system (LMNS) to review the recommendations made and produced a gap analysis and action plan of lessons learned in November 2022. Most of the actions were still ongoing, and some were overdue in October 2023. This demonstrated a slow response to risk.

Midwives followed prompts provided on electronic records to ensure all appropriate antenatal tests were completed following a gestational diabetes diagnosis. Audit showed staff had achieved 100% compliance for June and July 2023.

Staff involved the critical care team in antenatal multidisciplinary team planning for women with serious conditions. They had produced an SOP for a Maternal Medicine Pathway and referral to multidisciplinary team (MDT). Medical leads undertook monthly documentation audits to identify these cases and assess MDT referrals and involvement.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 5 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. Staff completed an annual MEOWS sepsis audit in September 2023 of all records for birthing people diagnosed with sepsis from January to August 2023 to check they were fully completed and escalated appropriately. Monthly compliance varied against a target of 85%, for recognition, diagnosis and early management of sepsis for these people. The overall screening compliance had dropped from 73% to 67%. Results showed maternity

patients with a MEOWS score of 3 or more were screened in 79% of cases in February 2023 to 56% of cases in April 2023. The most recent monthly compliance for September 2023 had improved to 88%. Results also showed people diagnosed with sepsis all received treatment within an hour. There were monthly actions identified to ensure learning was shared with timeframes and progress towards targets. All actions had been completed by September 2023.

The service provided a report on maternal deaths and morbidity reviews from 2022 which identified good compliance results in maternity areas for the monthly sepsis audits. It noted the audit did not review those presenting outside of maternity into other areas. The team had raised an action to establish ways to audit the use of MEOWS outside of maternity areas to enable action planning against results, but this action was 5 months overdue. This meant the service responded slowly to implement actions while risks remained.

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. The Specialist Perinatal Mental Health service (SPMHS) provided a duty worker Monday to Friday 9am-5pm to provide advice and in complex or high-risk cases, an operational manager, and psychiatrist. They could be involved in assessments during normal working hours. **The Maternal Mental Health (MMH) Service was a small psychology-led service which did not provide an urgent or emergency response**. The service provided urgent contact information to birthing people as well as an email inbox address for enquiries. The maternity service could access support from general adult mental health services for women and birthing people who had experienced baby loss or had their baby removed from their custody.

Maternity staff enquired about trauma history at antenatal appointments and referred women and birthing people to the specialist perinatal mental health services (SPMHS) at booking or on change in mental state. The perinatal mental health (PMH) midwife provided staff training regarding sensitive routine enquiry and asking about trauma history.

In June 2023, staff made 45 referrals to the SPMHS for women accessing antenatal and postnatal care. Of these, 36 referrals were accepted for assessment. The PMH midwife and MMH midwife had 323 episodes of supportive contact with women and completed 17 joint birth preference and mental health support plans. The service had been in operation for 5 years. Staff reported perinatal mental health conditions had increased significantly, and the team now served 10% of the birthing population.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff 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 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 staff involved in the woman's care, except for intrapartum notes that were recorded on paper. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and

birthing people and babies safe was shared. Staff had 2 safety huddles per shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. The service did not carry out SBAR audits.

Staff completed newborn risk assessments using recognised tools and reviewed this regularly. Staff carried out observations of newborns and completed newborn early warning trigger and track (NEWTT) assessments. The service provided minutes of a meeting from August 2023 that showed a NEWTT assessment had not been done and staff concluded deterioration of a baby could have been identified more quickly if this had been completed. The report noted early learning from the incident would be communicated to staff to ensure appropriate observations would be carried out. The service told us they did not audit NEWTT assessments.

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

The service reported monthly compliance with the Saving Babies' Lives care Bundle through the maternity dashboard and held discussions at Governance meetings. There had been marked improvements in measurements to identify diabetic markers (HbAc1 test). Staff had achieved 100% compliance in June and July 2023. There had also been an improvement in delayed cord clamping for babies born at less than 34 weeks. A reduced fetal movements workstream, for use in records for women and birthing people attending the fetal health unit, was not being used effectively and managers agreed to speak to staff regarding non-compliance.

The service reported their 'smoking at time of delivery' (SATOD) rates had slowly declined to 6.7%. This was an improvement over previous years but had not met the government's 2022 national ambition of 6%. The service recognised further work to reduce smoking during pregnancy was required. Clinical Quality Improvement Metrics (CQIMS) are a set of metrics derived from the Maternity Services Dataset for the purpose of identifying areas that may require local clinical quality improvement. Results at the trust were higher (worse) than the national average and in the upper 25% of all organisations, for two key metrics; women who were current smokers at booking appointment (12.3% compared to the national average of 9.1%) and women who were current smokers at delivery (10.2% compared to the national average of 7.9%).

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Women and birthing people experienced delays in care. The service had issues with retention and sickness of staff and were actively recruiting new and returning staff.

Managers could not always accurately calculate and review the number and grade of midwives, maternity support workers and healthcare assistants needed for each shift in accordance with national guidance. They said this was because the acuity tool (an IT based system) was not working properly. Following the inspection service leads told us the national electronic system was being updated which meant that temporarily this was not available.

The number of midwives and healthcare assistants did not always match the planned numbers for each shift. There were regularly 1 or 2 midwives less than establishment on every shift.

Maternity

On Delivery Suite there were 7 registered midwives. There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. One midwife was allocated to care for women and birthing people in triage, but they were included in Delivery Suite numbers and also provided care on Delivery Suite. This was against national recommendations and may not be enough to ensure safe care is provided.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day of inspection midwifery staffing met establishment and acuity requirements but staff told us this was not always the case. The most recent staffing acuity tool had been undertaken in 2021 and results at that time showed budgeted establishment was 0.89 WTE short of recommendations. The most recent safer staffing report showed actual staffing versus acuity for Delivery Suite was 79.2%. This meant there were insufficient staff to provide adequate care.

The antenatal and postnatal ward (Rowan Ward) manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice, and they were expected to work in areas unfamiliar to them. Following the inspection service leads explained all midwives were rotational and all had the skills associated. Staff could be moved at short notice to support one to one care in labour.

Staff on Rowan Ward told us they felt there were not enough midwives to provide safe care and low numbers of staff sometimes made them feel unsafe. One member of staff told us this impacted on staff morale and patient care, and staff cried every day because of staffing on the ward. Staff said the staffing establishment for the ward was 3 midwives, plus a ward manager. Staff told us one midwife would regularly be reallocated to Delivery Suite, thus leaving 3 midwives on duty including a supernumerary senior midwife to manage the ward. This meant there would be 2 midwives with 2 HCAs, to provide care for 32 antenatal and postnatal women and birthing people and babies, which was not safe.

Staff told us of delays in care due to shortage of staff and deliveries that had occurred on Rowan Ward because women and birthing people could not be accommodated on Delivery Suite. Staff said an instance of this had occurred the week before the inspection, and women and birthing people also experienced delays in care such as a 5-hour wait for sutures following a 2nd degree tear, and a 36 hour wait following premature rupture of membranes (PROM). Staff said they were not always able to provide personalised care or having sufficient time to spend with birthing people. They said some medicines were given late and there were occasions when baby observations were not done. These were safety incidents and there were very few examples of where these had been formally reported. Maternity support workers could help but there were limitations on what they could offer.

The service used an acuity tool to identify staff shortages and report red flags. They 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.

Staff told us, and reports to the trust board showed, the acuity tool had not been working so accurate staffing needs could not be measured. Staff told us they knew there were not enough midwives or MSWs and they did not always complete incident reports or red flags when staff numbers were low. This meant staff shortages were not always recorded.

Maternity

In September 2023 the service reported they were unable to download data from the ward acuity tool due to the website being unavailable for a further month. Service leaders told us this was a national issue and there were no alternative measures provided. Current acuity pressures and staffing gaps were being captured through completion of incident reports. However, since staff said they did not always incident report staffing issues, this could not be relied upon to give a clear picture.

Managers held a daily safety huddle to monitor, discuss and manage staffing cover across the service. Despite the ward acuity tool not being available, the service reported 115 red flags in September 2023. This was the same figure as for August and an increase from 102 in July and 64 in June. There were 105 reported for delayed artificial rupture of membranes (ARM), an increase from 85 in July. In July there had been 9 delays reported for augmentation of induction of labour (IOL), but none identified in the staffing report for September 2023, although medical staff and midwives said there were often delays in IOL. This meant there was insufficient assurance the data would be accurate.

There were 6 shifts in September and 7 in July when the Delivery Suite coordinator was not supernumerary but not delivering 1:1 care. Delivery Suite reported 100% for provision of 1:1 care for every month throughout the year and midwives confirmed every woman in active labour received 1:1 care.

The service's safer staffing report stated in July 2023 staffing on Delivery Suite met the acuity of the birthing people presenting in the service 86% of the time. They said in times of escalation due to staffing and acuity; the acuity requirements were met by following the escalation process, which included using the specialist midwives to support clinically as well as the midwifery managers. A midwifery manager on-call system was in place 24 hours a day, 7 days a week to support in times of staffing escalation.

Maternity leaders had completed a maternity safe staffing workforce review in line with national guidance in 2021. managers referred to this review for current staffing. It had recommended 144.45 whole-time equivalent (WTE) maternity staff Bands 3 to 7 which matched the funded staffing of 144.08 WTE, a shortfall of 0.37 WTE staff. There was a shortfall of 0.87 WTE for additional specialist and management roles.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. In August 2023 there were 31.3 whole time equivalent (WTE) midwife vacancies, a vacancy rate of 17%. This rate had increased from 12.1 WTE in March and 19 WTE in May 2023. Twelve midwives had left the service in the 6 months before the inspection. Managers reported to the safer staffing group in June 2023 they were frustrated that as soon as staff started, some left.

Ten WTE midwives would be going on maternity leave which would mean a deteriorating picture over the next 6 months and there were no additional plans to manage this. There were vacancies for maternity support workers (MSW) with 0.96 WTE at Band 2 and 1.92 WTE at Band 3. At the time of the inspection senior managers reported there were 17.3 WTE midwife vacancies. Managers met monthly with business finance managers and the human resource (HR) team to report and manage vacancies. The service used 12-16 WTE bank staff, and explained they did not use agency staff. The service had increased its student numbers by 100% since the previous year and there were 3 cohorts qualifying this year, already interviewed and offered positions. The high turnover rate meant the service needed to continue to recruit. They had a project to widen the scope of advertisement with the hope to target a wide range of applicants.

Managers calculated, when long term sickness and maternity leave were accounted for, the staffing shortfall increased to 22.8%. The midwifery staff sickness rate reported in August 2023 was 4.3% short term sickness, an increase on the previous month, and 5.8% long term sickness. Staff told us sickness rates were increasing as staff became more stressed. The HR and occupational health teams provided ongoing support for staff on long term sickness, with supportive plans to support them back into work.

The service expected the vacancy rate to improve following recent successful recruitment. Seven new registered midwives started in post in September, with a further 9 midwives appointed and due to start between October and December 2023. Student midwives due to qualify had also been appointed.

Managers said the focus on recruitment and retention continued. The trust supported retired midwives returning to practice. The professional midwifery advocates (PMAs) had undertaken restorative supervision sessions with all midwives in July 2023 to improve retention, and previous high turnover of newly qualified staff had improved with the implementation of a dedicated preceptorship midwife. The service offered an enhanced preceptorship package to provide skills for Band 5 midwives going into the community. This is against the Ockenden report recommendations to send Band 5 staff to community settings and the service would need to be assured they had the right skills and support. There was ongoing work with a new competency framework for MSWs to uplift from Band 2 to Band 3. The service had reported a lot of the MSW Band 3 establishment had moved from the unit out to community settings. This had created a gap in the unit and more MSWs were being recruited. Managers attended a monthly joint meeting with maternity and finance to record the workforce data submission to NHSE.

The service relied on midwifery bank staff to improve fill rates. The bank included two gynaecology nurses who provided postnatal nursing care on Rowan Ward. The service reported a reduction in the number of bank shifts filled in August and this had a negative impact on service delivery. Managers reported the unavailability of midwives remained high at around 35-40%. The service was in consultation with all midwives regarding provision of an on-call system.

During our inspection, we observed a woman in the triage bay was not receiving care and it was not clear why the named midwife covering triage was not there. We informed staff at the Delivery Suite nurses station who arranged for a midwife to attend immediately.

There was a bay on Rowan Ward set aside for transitional care (TC) babies. Midwives provided this care. The service had recently posted an advert to recruit a TC lead midwife.

There was a team of midwives who cared for birthing people before and after planned LSCS. Planned LSCS lists ran from Monday to Friday with 2 or 3 women and birthing people per day. In September 2023, the team had attended 49 LSCS.

There were 12 home deliveries across all areas. Continuity of carer teams provided care for 9.5% of women although this was higher at 27% of women in July 2023. For the same month, the 2 teams of continuity of carer midwives had attended 63% and 53% of their inpatient deliveries.

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.

Managers supported staff to develop through yearly, constructive appraisals of their work. A practice development team supported midwives. The team included a practice development lead midwife. The appraisal rate for registered midwives was 84% and 86% for unregistered nursing staff.

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

There was a total of 30 midwives who were qualified to complete Newborn and Infant Physical Examination (NIPE) screening. A further cohort of midwives were being trained on the day of the inspection. One midwife was allocated each shift to carry out NIPE screening to facilitate timely discharges.

Midwives completed NIPE checks between 8am and 12 noon on weekdays, paediatric doctors completed any others required. Staff said there was no formal process for this and there were regular delays in waiting for paediatric doctors to carry out NIPE checks.

There were opportunities for staff development including twice-monthly shifts as deputy sister for midwives interested in progression. Eight community midwives each came into the unit on rotation for a shift once a month to maintain skills.

Managers made sure staff received any specialist training for their role. For example, Delivery Suite coordinators, matrons and the Head of Midwifery had completed a leadership course.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to meet consultant numbers and on-call shifts but there were not enough suitably qualified or competent staff to provide medical cover for triage or LSCS lists or a senior presence to manage the triage or the antenatal assessment area. This had been included in the service risk register. This did not meet service requirements. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. There was a budget for 10 WTE consultant obstetricians and 8.8 WTE were in post. Trust managers explained 2 consultants were not part of Delivery Suite or on call rotas, which left a shortfall. However, consultant presence on Delivery Suite had increased to 66 hours per week, to meet the recommendations from the Ockenden review in 2020.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Locums on duty during the inspection told us they were well supported and received a comprehensive induction.

There were 3 associate specialist doctors and 3 trust doctors who contributed to the middle grade on-call rota. There were 5 specialist trainee doctors (registrars) of grades ST4 and above. All specialist trainee doctors working on the middle grade rota completed the basic competencies required to cover Delivery Suite.

There were 3 daily multidisciplinary ward rounds on weekdays and 2 per day on Saturdays and Sundays and all relevant medical staff were involved. The team involved were the consultant obstetrician, obstetric registrar or associate specialist doctor, obstetric SHO, consultant anaesthetist, anaesthetic staff grade doctor or registrar, Delivery Suite co-ordinator, representatives from special care unit and theatres. We observed the Delivery Suite ward round and these staff all attended and took a full part in the round. Staff said there was always a consultant on Delivery Suite during the day and they were available at night if needed. Trainee medical staff told us rotas were fair. All staff were friendly, and the team supported each other.

Another local trust provided a Fetal Medicine service to the trust, and they had offered to extend the provision. At the time of the inspection, the team was mapping out their requirements for further discussion about ongoing provision. It had been agreed this would be recorded as a county-wide risk on the LMNS risk register.

There were 6 anaesthetic consultants with a primary specialist interest in obstetric anaesthesia. There was a dedicated consultant for obstetric anaesthesia allocated to the emergency obstetric theatre from Monday to Friday between 8am and 6pm. There was an additional consultant anaesthetist or associate specialist responsible for the elective LSCS list. In addition, there was a dedicated middle grade anaesthetist allocated to Delivery Suite during the same times who held a 3rd on-call bleep.

Midwives reported they experienced difficulties obtaining a medical review following a LSCS. The junior doctors completed these reviews, but midwives said they were not available on the ward until 11am or 12 noon. Birthing people we spoke with told us they had experienced delays in receiving pain relief when they needed it.

The service always had a consultant on call during evenings and weekends. The on-call rota covered obstetrics and gynaecology. There was an on-call consultant for 24 hours every day covering Delivery Suite. In addition, there was a consultant present on Mondays to Thursdays from 8am to 7pm, Fridays from 8 to 6pm, and on Saturdays and Sundays 9am to 1pm and 8.30 to 10.30pm.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The appraisal rate for medical staff was 94%. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop. Medical staff spoke highly of the consultants and all grades of medical staff, and said all staff were supportive. They felt able to ask for help on Delivery Suite and in theatre and staff were responsive.

Senior leaders reported the service was ranked first in the region for medical education from the deanery. They said they had the best scores for trainee results, and for clinical support outside of hours. The service was compliant with General Medical Council (GMC) standards with green ratings for medical supervision, training, and rotas for over 5 years. The 2023 GMC survey results showed scores at the trust were significantly better than the national average for 2 indicators; supportive environment and local teaching, and above average for two indicators; educational governance and facilities. The remaining 14 indicators were within the average range for similar services.

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. Staff did not always ensure correct patient ID information was used, including baby ID bracelets and labels used for tests.

Women and birthing people's notes were detailed, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 9 electronic medical records and found records were clear and complete.

Staff maintained antenatal and postnatal records on the patient's electronic maternity care record. All records were electronic apart from the intrapartum care record, where staff used yellow perinatal institute paper notes. Staff scanned additional records of care such as CTGs, MEOWS charts and the intrapartum notes onto the patients record. These were accessible for all staff to view via a separate electronic viewing system. Following the inspection, staff told us observations noted on a CTG were also recorded into the electronic record.

We looked at 9 sets of records where most of the antenatal information was complete except in 1 case where staff had not documented if they had asked about domestic abuse and no reason had been given. In the intrapartum sections we

found information was missing in 3 out of 9 CTG records. We found end of CTG documentation was not completed on 2 cases, and another CTG record did not include the person's name or gestation. There were results from recent audits which showed compliance had not always met the trust standards and this showed staff were still not completing all records correctly.

Staff reported in the quality newsletter in August 2023, and incident records confirmed, between November 2022 and November 2023 there had been 9 incidents where the wrong person's information had been documented. These included 2 baby identification bracelets with incorrect names, incorrect names on records for 2 baby transfers, incorrect name or information was provided on 3 discharge documents, and 2 incidents where the wrong patient details were provided for laboratory test requests. This meant there was not enough care taken by staff when completing documentation and a risk that a birthing person or baby may receive the wrong care.

In contrast, staff recorded demographic information and a recent records audit showed compliance for antenatal completion of religion documentation had increased to 80%. This was the highest level seen in 2023.

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

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

Medicines

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

Staff did not always complete checks to ensure medicines were stored and managed safely. On Rowan Ward there were gaps in temperature check documents for fridges and freezers. Missing recordings ranged from 6 occasions in April 2023 to 8 for May and a further 8 in June 2023 for periods between 1 and 3 days. There was a further gap of 23 days in July when checks were not recorded. There was a period when the medicines room temperature ranged between 29 and 32oC, and staff had not completed fridge temperature checklists. This meant staff would not have known if, and for how long, medicines were stored outside of the safe range for their use. When we raised our concerns about incomplete checks with managers on Rowan Ward they were unaware checks had not been documented. All checklists on Delivery Suite were fully completed.

We found medicines used to treat postpartum haemorrhage (PPH) (Syntometrine and Ergometrine) which should be kept refrigerated, were stored outside the fridge, and staff labelling of packages was inconsistent. Staff had marked some packages of Syntometrine with dates showing when they were removed from the fridge, but other boxes of the same medicine had no dates recorded. This meant staff would not know if those medicines were safe for use, or if their use by dates would be affected.

Staff had reported 24 medicines errors as incidents since 1 November 2022. These included missed doses of prescribed medicines, intravenous (IV) antibiotics given to wrong person, medicines given twice, and incorrect doses calculated but noted by staff before administering. There was evidence of learning shared and actions taken to prevent incidents recurring, but staff told us most errors were due to shortages of staff, interruptions, and insufficient time available to complete checks before administering medicines.

On Rowan Ward we found expressed breast milk in the milk fridge had been labelled as containing breast milk fortifier, but it had not been prescribed in the drug chart and there was no documentation in the milk diary that it should be added. Staff did not know if it had been added to previous feeds or for how long. Staff immediately reported this to the deputy ward manager.

The clinical room where medicines were stored was locked and could only be accessed by authorised staff. Staff used an electronic key system to access medicines rooms. A key would be allocated to a staff member for the duration of their shift which, if lost, could be de-activated. On Rowan Ward, we observed the medicines cupboard, although behind a locked door, was left open. This did not meet safe storage of medicines requirements and staff not authorized to handle or administer medicines could access them.

We found a large stock of medicines in a cupboard waiting for collection by women and birthing people who had been discharged and opted not to wait for medicines to be delivered to the ward before going home. Staff explained people might say they would return for prescribed medicines but did not come back. Staff said they should carry out weekly checks and these medicines should be returned to pharmacy if not collected after a period of 10 days, but we found labelled packages were from beyond this timeframe. For people not wanting to wait for delivery of medicines, staff would provide medicines from the ward stock where possible.

Staff checked controlled drug stocks daily. Although not all temperatures were recorded, staff knew to act if a variation to safe temperatures had been noted.

Prescribing documents and medicines records were mostly complete. Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Staff used both paper and electronic systems to record medicines. Women and birthing people on Delivery Suite had paper prescription charts and electronic records for medicines were held on Rowan Ward. Staff said Delivery Suite had used the electronic record system up until 2 months before the inspection, but the service had noticed an increase in medicine errors had occurred whilst using the electronic system. To mitigate the risk of further errors and possible missed medicines on transfer from Delivery Suite to the postnatal ward, doctors completed prescriptions using the electronic patient record prior to transfers and midwives told us they would check the paper record as a failsafe. The 8 sets of medicine records we looked at were accurate and up to date, although we found one of these records did not document allergy information.

On Delivery Suite medicines were in date and were stored at the correct temperature. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people and carers about their medicines. There was no dedicated pharmacist for maternity, but the pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the medicine documentation we checked. The pharmacy team shared audit outcomes with ward managers and these in turn were reported through governance processes.

Staff learned from safety alerts and incidents to improve practice. Managers shared safety alerts with staff through bulletins and safety huddles.

Neonatal nurses came to the ward to administer intravenous (IV) antibiotics for babies and midwives provided second checks. If the ward was unable to facilitate the 2nd checker role, then the baby would need to go to the neonatal unit for their antibiotics.

Maternity

Incidents

The service managed safety incidents well. Staff recognised and reported clinical incidents and near misses but did not always report incidents regarding staffing levels. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented but not always monitored or closed.

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 283 incidents reported in the 9 months before inspection and found them to be reported correctly.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. However, actions were not always taken or closed in a timely way. Lessons learned from serious incidents and perinatal mortality review tools (PMRT) carried out in the 6 months before the inspection included ensuring all women and birthing people received all appropriate antenatal scanning and follow ups including any required treatment. Other actions identified and carried out were improvements to translation services, smoking cessation resources should be offered to all partners and carbon monoxide (CO) should be measured at booking appointments. These were shared and were to be actioned by the appropriate staff. These and subsequent actions, such as audit to confirm changes had been made, remained open at the time of the inspection. Other open actions included updating a standard operating procedure (SOP) to ensure staff made timely consultant care or specialist clinic referrals following antenatal findings.

Managers reviewed incidents potentially related to health inequalities Information gathered at booking included ethnicity, religion, language used and mental health. Staff audited records and incidents and identified learning and actions in relation to inequalities.

Managers debriefed and supported staff after any serious incident. Following a recent serious incident staff had held an immediate debrief to allow for a brief, open discussion about the incident in a safe environment and without judgement. Managers also organised a group session to discuss the case and staff were offered support by the staff health and wellbeing team. More formal reviews of all serious incidents were carried out following governance processes and perinatal mortality review multidisciplinary team (PMRT) meetings were held jointly with the neonatal service.

Managers communicated Incidents with staff through governance newsletters, safety huddles and staff handovers.

Most incidents were graded as low or no harm, with only 18 graded as moderate harm or above between 1 October 2022 and 1 September 2023. Grading of incidents was changed only as a result of an MDT review decision and reviews took several months to complete. The quality newsletter for September 2023 showed the number of incidents reported was 57 and of these 30 were graded as no harm, 14 as near miss, 1 as low psychological harm, and 12 as low harm.

Staff completed briefing papers and presented cases for discussion at monthly maternity round table meetings. Examples of harm following incidents included 3rd and 4th degree tears, an episiotomy requiring 4 cuts and resulting in an additional 3rd degree tear, and damage to a birthing person's bowel during a caesarean section. These were all graded as no harm or low harm. These categorisations of harm did not reflect the impact of the psychological and physical effects caused by these incidents.

Maternity

Staff reported serious incidents clearly and in line with trust policy. We noted intrauterine deaths were declared as serious incidents but found these were regularly downgraded to no harm following internal investigation. Although the service provided evidence to show they followed a very clear process using PMRT, it was not clear how or why the investigating teams downgraded the level of harm in these cases. This meant reporting to external organisations was not transparent, linked to the organisation's reputation rather than recognition of suffering. There were also missed opportunities for learning from such cases.

There had been 2 maternal deaths in early 2023. Both cases were presented at the service's serious incident review group (SIRG) and referred to HSIB for investigation. In both cases, care at Kettering General Hospital was deemed to be appropriate.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. Managers reviewed all incidents, completed 72-hour review reports, and held round table discussions to escalate to serious incident reviews if required.

The service had reported 6 serious incidents between October 2022 and September 2023. We reviewed 2 serious incident internal investigations and found staff had involved women and birthing people and their families in the investigations. The CQC local inspection team had raised concerns with the trust prior to our inspection. The trust had advised they had undertaken work to improve the process. This included professional duty of candour by healthcare professionals in being open and honest and also the statutory duty of candour.

Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. Staff we spoke with understood the duty of candour. We asked the service to provide copies of duty of candour letters and they shared 3 letters, 1 of which had been written before the inspection. Staff completed incident investigations before written duty of candour was carried out. Staff said they were open and transparent and gave women, birthing people and families a full explanation if and when things went wrong, but formal duty of candour was not always completed in a timely way. There were examples where 3 or 6 months had elapsed between recording of an incident or receipt of a complaint and provision of a formal written duty of candour letter.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to the care of women and birthing people.

There was some evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medicine incident. The patient safety lead midwife discussed learning identified and actions that had been raised from previous serious incidents. In particular incidents regarding CTG findings and growth scans had launched some immediate implementation of changes. One case was being considered for escalation to the serious review group.

Managers shared learning with their staff about never events that happened elsewhere. Staff attended joint Perinatal Mortality MDT Meetings with the neighbouring trust every 2 weeks. Good attendance was recorded from the multidisciplinary team including the clinical director, matrons, risk and governance midwives and bereavement midwives. The team discussed cases that had been reviewed, their outcomes and actions to be taken.

Staff produced a monthly maternity safety report. In the April report, staff presented data from February 2023 which showed they had noted an increase in perinatal mortality with 4 stillbirths. Information provided was very brief, but the team looked for themes and learning opportunities. There had been a range of causes including a first admission with

reduced fetal movements (RFM), a compassionate induction of labour and an admission for a baby small for gestational age (SGA). One case involved a missed referral for a twin pregnancy to the premature birth prevention team following cervical trauma. This was not in line with The NICE guideline for preterm labour and birth (NG25). There was no record in this document of actions taken to learn from these cases or prevent them from recurring.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders generally had the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. There were different management styles and practices across wards, and leaders were not always aware of staff concerns, safety, environment, or cleanliness levels across the whole department. Leaders and managers were visible and approachable in the service for women, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service but did not always understand and manage the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. The leadership team was a quadrumvirate of the director of midwifery, the clinical director, the chief of family health division and the interim senior service manager. The team reported to the trust's triumvirate, the chief nursing officer, the chief operating officer, and the medical director.

The head of midwifery line-managed 3 matrons, the lead professional midwifery advocate and a lead midwife for women's ultrasound. The trust used a 'ward to board approach' to reporting quality, and safety data showed the reporting structure was clear and easy to follow. However, when we informed managers and leaders of our concerns on Rowan Ward, they had been unaware records were incomplete and the environment was not clean. Managers and senior leaders were not aware emergency equipment had not been regularly checked and some emergency medicines were not available to staff. This showed governance processes were not always effective at identifying and managing risk.

Consultant leads met monthly and followed a formal agenda to review their action plans of major concerns, which included workforce development, safety, training, and educational events. The service operation manager attended the meetings and after the meetings informed the other obstetric staff of outcomes and any changes via individual emails.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

Maternity safety champions and non-executive director (NED) supported the service. The midwifery safety champion reported to the board every month and they both attended executive safety meetings. The NED had been working with the trust since January 2023 and understood the needs of the local population. The NED attended monthly meetings with service level safety champions and completed weekly walkarounds of the service. They had a '3x3x3' approach to

reviewing service provision. This meant they made sure they spoke to 3 mothers, and 3 members of staff, and looked at 3 feedback on care forms. The NED chaired the safety quality committee meetings and reviewed the quality safety report. They also attended senior midwife and senior nurse meetings. The director of midwifery (DoM) reported the monthly Maternity Safety report to the Clinical Quality Safety and Performance Committee in Common.

The NED had a role in reducing risks to women from ethnic groups at higher risk of poor outcomes. They looked for assurance from service leaders that they had oversight of the needs of the local population, implemented services like the continuity of carer, and proactively used soft intelligence to look at themes to see if there were any groups that were underrepresented. They identified that not everyone was able to make complaints, and this was why soft intelligence was vital to ensure vulnerable groups had a voice.

Leaders and managers 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.

All perinatal losses were reported to MBRRACE-UK within 7 working days and the surveillance completed 7 working days. Managers reported this was above the requirement for the surveillance to be completed within 1 month for CNST requirements. All parents were informed of the review process and asked if they had any specific questions or concerns to be considered. Written information was provided in line with MBRRACE-UK and SANDS recommendations.

Vision and Strategy

The service had a joint vision developed with a neighbouring service. They had developed an NHS hospitals local group strategy that was focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders wanted the vision and strategy to focus on sustainability of services and align to local plans within the wider health economy to safely plan for the next 5 years.

The leadership team were developing their own 3-year service delivery plan for maternity and neonatal care to supersede the Ockenden and Kirkup actions in consultation with the NED and maternity safety champions. After the inspection leaders sent us the updated 3-year delivery plan which included themes around; listening to, and working with women and families with compassion, growing, retaining and supporting the workforce, developing and sustaining a culture of safety, learning and support, and standards and structures that underpinned safer, more personalised, and more equitable care.

Theme 1 used the CQC national maternity survey and the friends and family feedback form as data sources to create measures that focused on listening to the needs of the people using the service. Theme 2 used staff surveys to create measure which focused on the workforce. Theme 3 also used the NHS and the general medical council's staff surveys to create measures. Leaders used national reports like MBRRACE-UK and NHS digital systems.

The service had received feedback from the local maternity and neonatal systems (LMNS) about their Ockenden (2022) assurance visit. The LMNS were assured most aspects of care rated as green (safe).

A financial capital program for upgrades to the estate was due to be completed at the end of the financial year.

Culture

Maternity

Most staff felt respected, supported, and valued, although a small number of staff spoke about difficulties with communication between teams and some instances of discrimination. Staff were focused on the needs of women and birthing people receiving care. The service provided opportunities for career development. The service supported women, birthing people, and their families to raise concerns without fear.

Most staff felt respected, supported, and valued**.** Staff were mostly positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. However, not all staff said they felt there was a good culture and a small number of staff spoke up about examples of discrimination towards staff and people from ethnic minority groups. Staff reported some of these concerns had been actioned and work was ongoing.

Some staff described the relationship between Delivery Suite and Rowan Ward to be sometimes difficult. They felt Delivery Suite took much needed staff from the ward to meet their staffing and acuity needs. Staff told us “People are leaving because they are being moved around the wards, not wanting to be moved. They had “never seen staff turnover like it is now”. “Some leave and then take shifts on bank because they are allocated where they want to work”. “I find myself dreading coming into work, and it impacts on patient care”. “Managers say they are working on it, but it’s a 5-year plan”. “This has been going on since Covid”.

Rowan Ward staff reported they experienced poor communication from the paediatric team. Staff gave an example of a woman preparing to go home on the day of the inspection. The team looking after the baby had told the family they could go home but they had not informed the ward staff. This meant there were unnecessary delays in discharge.

The NHS staff survey results including the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) showed scores were below the average for comparable services. The areas We are compassionate, and We are a team scored the lowest of comparable services. Scores for Staff Engagement and Morale in 2022 were significantly lower compared to 2021 scores. WRES metrics showed results for staff from all other ethnic groups were notably different to results for white staff, indicating poorer experiences for staff from all other ethnic groups. WDES metrics results for staff with a long-term condition or illness were notably different to results for staff without a long-term condition or illness, indicating poorer experiences for staff with long-term conditions or illnesses.

Fewer than 30% of staff had responded to the staff survey and leaders reported the service “did not do well in relation to maternity services in other organisations, which was reflected nationally. However, at Kettering, the maternity service benchmarked even worse in most of the areas against the rest of the organisation. The service reported that although the results were poor, they were an improvement on the previous years.

Leaders had responded to concerns raised during the division’s staff survey, and developed and reviewed a rag rated (red, amber, green) action plan to reduce staff concerns regarding certain aspects of their working lives. The records showed workload, lack of breaks and working additional unpaid hours were the main concerns. Leaders monitored staff wellbeing via informal surveys, listening events and via reports from and to the Freedom to Speak Up Guardian (FTSU). They stated since the survey was undertaken, they had added a lead professional midwifery advocate (PMA) to provide more support to preceptors and had started seeing an improvement in attrition rates. They had introduced a QR code which staff were using at the end of each shift to highlight any concerns that could be addressed by the lead PMA within real time rather than waiting for a survey a year later. Leaders stated they planned to launch an organisational, cultural piece of work across the whole of the organisation where cultural mentors or ambassadors would support the divisional teams to improve their staff survey results.

The service introduced the ‘SCORE’ survey in August 2023. SCORE stands for Safety Culture, Operational Risk, Reliability/ burnout, and Engagement. Through a series of short questions, the survey aimed to assess aspects of local team culture,

including safety, communication, and teamwork. The initial audit response rate was 31% and leaders completed daily walkarounds of the unit to encourage staff to complete the survey, with a final response rate of 64%. The service reported the SCORE survey was completed in October 2023, but analysis had not been completed. The next stage of the plan was to target community teams and new doctors who commenced in August to encourage completion. Regular communications were also being sent out to staff via email and closed social media.

Leaders told us they were committed to supporting staff and were nominated for the safety culture leadership programme.

The director of midwifery led by example, they told us they worked an occasional night shift to ensure they had oversight of services and culture at night, they walked around the unit which promoted open communication with all staff. The freedom to speak up midwife ensured anonymity for any staff who raised concerns.

One example of teamwork and support was that within the unit it was traditional in the week before Christmas all obstetric and gynaecology medical staff cooked for all the staff.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture which placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect for women and birthing people were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

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. 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. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said it helped them understand the issues and provide better care.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment. The Sheffield Maternity Alliance Group facilitated a 2-day course for midwives and medical staff on cultural competence. Service leaders supported staff to attend and had set up a midwifery equality group with 8 midwives from different ethnic groups included in the group. It was not clear if the service had developed terms of reference or actions regarding this group at the time of the inspection.

Service leaders made sure staff who had pre-existing medical conditions were referred to occupational health and where appropriate made reasonable adjustments to shift patterns.

The service had a safety culture where women, birthing people, and their families could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. Managers said complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people's 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 and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. The service received 7 complaints from July to

November 2023; 5 were about poor birth experiences, 1 was about infant feeding and 1 about antenatal care. All complaints were recorded. Records showed 1 complaint remained open from July 2023. However, it was a complex complaint therefore required a root-cause analysis investigation. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

The service had received positive trainee doctor GMC survey results. Staff reported the trainee survey results were one of the best in the region. Results demonstrated continued (year on year) improvements and a friendly healthy culture starting from senior doctors to midwives.

Most staff we spoke with said they supported each other and worked well as a team. They were good at sharing learning and knew the service would implement change when necessary. Some staff had worked in the service for almost 20 years. Staff said Kettering was historically where midwives came and stayed, but they explained more junior staff were coming through recently.

We observed good relationships between obstetric medical staff and midwives, although some staff described professional relationships as complex, so staff were not complacent. The clinical escalation tool sometimes caused conflict. This could be with doctors who had been there longer. Staff said “we wouldn't be naive enough to think we don't have an issue” particularly when it had been highlighted on a HSIB report that there were barriers to clinical escalation. Staff reported a follow-up meeting was planned to discuss this further.

Managers said the director of midwifery took a more approachable role than previous leaders and they saw more of senior managers than before. Staff said matrons were “great” and staff “don’t have any issues with any of them”.

The service provided regular student placements. We met student midwives and a student paramedic undertaking work placements. All spoke very positively about their experience and the supportive staff.

The service launched a Month of Wellbeing in August, hosting 3 events designed to celebrate maternal wellbeing. These included; a wellbeing walk, a festival to include families, and booked personalised sessions with the wellbeing midwife. These had topics including; smoking cessation support, vaccination offers, nutrition, and physical activity.

Governance

Leaders operated 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.

The service had a governance structure to support the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a series of well-structured governance meetings.

The Family Health Division Integrated Governance and Business Meeting was held monthly and leaders from across the division attended. The meeting made sure that leaders had oversight and monitored their financial, operational delivery and performance, health and safety, human resource management and service developments commitments.

The maternity safety champions, including non-executive directors held a maternity safety meeting and reported into the board monthly. Directorate governance meetings were well attended by consultants and specialist midwives.

Maternity

The governance team produced a quality newsletter with monthly updates on management of risk, reported incidents and themes, serious incidents, mortality, and morbidity. They reported changes to clinical guidelines and updates. The team accessed a closed social media page and team channels. In addition, there were governance notice boards on Rowan Ward and Delivery Suite.

The maternity service participated in completing the regional and LMNS situation reports as well as attending the LMNS daily staffing huddle. The LMNS Safer Staffing Group tracked this, and the regional networks supported the maternity services in accessing mutual aid in times of escalation due to staffing or capacity form other maternity services. The LMNS had also developed a regional perinatal network and an escalation policy.

The risk midwife shared learning from serious incidents through; study weeks, a briefing paper shared across the trust, the LMNS, and a risk brief shared to rest of organisation. They also shared information from the LMNS and the NHS futures platform, (an online collaboration platform that empowers everyone working in health and social care to safely connect, share and learn across boundaries).

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. Service leaders had responded to the recommendations of the Ockenden report (2022) and completed a risk assessment. All measures were RAG rated and monitored with planned review dates. Staff used the monthly obstetrics and gynaecology governance meeting to share and discuss the perinatal dashboard and key metrics including Ockenden review actions and staffing red flags. Staff compliance to completing screening was not always above 85% which is a required standard for the saving babies lives care bundle. The assessment highlighted 2 other areas of improvement were required which were; lack of centralised cardiotocograph (CTG) monitoring, and the lack of supernumerary Delivery Suite co-ordinator specialist training. Senior staff told inspectors they did not feel centralised CTG monitoring would be beneficial to the service. This was identified on the risk register, but they felt it would have a negative impact on the current holistic reviews undertaken for all birthing people.

The Obstetrics and Gynaecology (O&G) Governance and Business operational meeting had been established to create a single line of accountability to report to the main divisional meeting. The O&G sub divisional meeting had responsibility to escalate any issues to Family Health Divisional Steering group which will have potential impact across the organisation and was accountable for service issues.

The divisions clinical quality, safety and performance committee reported to board directors. Service leaders recorded outcomes on the services perinatal dashboard which monitored themes and trends. The data was used to identify themes and trends to help inform service delivery and quality improvement measures.

The director of midwifery produced the maternity quality committee report using a standardised template and shared this with the NED and the trust board. The NED told us that the reports were of good quality with realistic time frames for improvements. One example of change was improvements to the distribution of information on fetal movements in different languages to be more inclusive with patient care.

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

Maternity service leads produced monthly newsletters included current risks, summaries of reported incidents and themes. These were shared with staff through handovers, safety huddles, staff email and displayed on noticeboards.

Maternity

The service had quarterly perinatal mortality reviews. The review group identified cases which included care issues that made a difference to the outcome for mother and baby. Leaders shared serious incident outcomes with staff. The service's perinatal mortality review showed all perinatal losses were reported to MBRRACE-UK within 7 working days and surveillance for all was completed in 7 working days. All parents were informed of the review process and asked if they had any specific questions or concerns to be considered. Written information was provided in line with MBRRACE-UK and SANDS recommendations. The review showed a further 3 had external reviews. There were 2 cases in September 2023 and 3 ongoing cases referred to Maternity and Newborn Safety Investigations Special Health Authority (MNSI). The service had received letters with 2 escalations of concern in July 2023 for cases which had been presented by the director of nursing in the perinatal mortality meeting in May 2023. Leaders informed staff both letters had been responded to by the chief nursing officer and medical director and actions put in place to address the concerns raised. A further meeting had been planned between trust executives and MNSI following the inspection in October 2023.

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

The trust worked in collaboration between Kettering General Hospital and their neighbouring NHS Trust. This had created committees in common for finance, performance, quality, and safety in November 2020. Committees in Common are a recognised governance approach that enables collaborations between organisations to take decisions together on projects that cross boundaries without compromising the integrity of their own statutory requirements. This local working enabled the service to share learning from incidents and to encourage discussion around staffing, performance and to encourage challenge particularly at director level.

Results from the 2022 CQC Maternity Survey showed Kettering General Hospital scored in comparison to other trusts, about the same for 48 questions, 'better than expected' for 1 question: and 'somewhat worse than expected' for 2 questions. These were regarding support for mental health during pregnancy and after giving birth. Scores when compared to 2021 results showed improvements in monitoring and giving support on mental health during antenatal care and feeling spoken to in a way they could understand during labour and birth. Some areas where scores had decreased were for partners staying as long as they wanted to, people wanting more information before being induced, and advice, support and information during labour and in hospital after the birth. Additionally, some respondents reported not being given information, such as not being told why their induction was delayed. There were also issues with supporting the feeding of babies. There were multiple incidents of inconsistent or no support with this.

Staff interaction was notably more positive than negative in this trust, with staff described as "lovely", "caring", "helpful". Some respondents reported positive psychosocial support. One spoke about a member of staff "great at calming me down and trying to make sure I had the best experience I could". However, some respondents described experiences with rude or dismissive staff. The maternity survey recorded comments from people who shared they were from ethnic minority groups or with mental health conditions. Comments were mainly very positive with only 3 out of 13 people giving negative comments; 1 felt staff did not listen and had to wait for pain relief, another person felt they had not been given sufficient information about their baby's condition after the birth. A birthing couple felt they had not been given enough support and advice which caused them some distress, and they felt disappointed in the care they received in hospital.

Management of risk, issues, and performance

Maternity

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. Outcomes for women and birthing people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. National audits included (but were not limited to) The National Diabetes in Pregnancy audit, The Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care Report 2022 maternal deaths and morbidity and the National Maternity and Perinatal Audit – NHS maternity care for women with a body mass index higher than 30.

Managers and staff carried out a programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Records showed there were 32 audits in progress for the year April 2023 to March 2024. A further 9 audits were pending for the following year. Local audits included the use of CTG stickers during childbirth, records audits, skin to skin at delivery, quality of care, and consent for people undergoing LSCS.

Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly Risk Assurance meeting. The leadership team took action to make change where risks were identified.

The obstetrics and gynaecology governance and business operational meeting had a formal agenda, which included updates from the Maternity and Neonatal Voices Partnership (MNVP) who provided a service user story which was used to share learning and outcomes and understand the patient journey. The meeting looked at various aspects of care which included (but was not limited to) current risks, patient safety, the governance report and reviewed the maternity dashboard. The meeting also received safeguarding reports which highlighted the most serious adult and child safeguarding concerns including reports from the high court.

In September 2023 the top 3 risks to the service were the vacancy and sickness rates and required updates for the bereavement suite. An additional new risk had been added for "documentation". It said the service "struggled to establish a robust digital system". Managers also reported on the use and measurement of nitrous oxide (also called gas and air, used to control pain and anxiety) following a national patient safety alert in March 2023. All rooms on Delivery Suite had a nitrous oxide scavenger unit. The service carried out 6-monthly tests for every room on Delivery Suite. There had been no high-level readings and the service had purchased personal monitors for staff. Community midwives and Rowan Ward staff could also use personal devices.

Service leaders had oversight of the health inequalities associated with various ethnic groups and implemented several strategies to tackle these. The service covered an area of social deprivation and various markers were reviewed to inform care. For example, ethnicity, smoking status, body mass index, and language. Leaders recently recruited to a safeguarding role to focus on substance and alcohol misuse during pregnancy. An audit of the use of translation services at each clinical contact had been carried out with 9 months' retrospective study up to June 2023. On completion, the results would be presented through the service governance processes. One early action arising from the audit, noted in

governance meeting minutes from August 2023, was staff would be “reminded of the importance of documenting when translation has been declined, explaining to the patients that they may be inadvertently putting themselves at risk by using a family member to translate (who may unable to translate intimate details or medical terminology correctly)”. The use of professional translation services had been added to the risk register.

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

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

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. There were differences throughout the service in types of medical records used, and staff access to them. This posed a risk to inconsistency and availability of necessary and up to date information. Staff could find the data they needed to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They 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.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were secure. Staff accessed different data systems depending on the information held and areas people were located. For example, staff in the special care unit used the trust electronic system but staff used a separate recording system for babies receiving transitional care. Paediatric staff had access to the paper intrapartum notes. Medicines were recorded on paper in Delivery Suite but electronically elsewhere. Staff said Delivery Suite staff would update the electronic medicines records for transfers to the postnatal ward. These differences in formats for medical records and access posed a risk to inconsistency and availability of necessary and up to date information.

Perinatal mental health midwives had reciprocal access to electronic maternity records at the sister NHS trust. Leaders explained there was system-wide work in progress to overcome gaps in digital access and therefore improve information sharing.

Data or notifications were consistently submitted to external organisations as required.

Engagement

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

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Service leaders had regular engagement with the community and the local MNVP lead.

A Patient Experience midwife had been recruited and was due to commence in post in October 2023.

Maternity

The service provided interpreting services for women and birthing people and collected data on ethnicity.

Leaders understood the needs of the local population. Leaders monitored outcomes for women and collected ethnicity data when women and people booked for care. This helped tailor services to meet local needs. Northamptonshire is a diverse county with a large Polish, Romanian and African population.

The NMVP provided information to people from socially deprived areas, held and joined community groups to hear a diverse group of voices, especially those seldom heard. They ensured leaflets were available in the to the top 5 languages used in the area. There was a social media page with 3000 members and staff reported large levels of engagement using this. They sent details of events and interaction surveys and reported good response rates. They reported good links with local mosques and community groups for those from ethnic minorities, and good integration through online resources, but there was also ongoing work to make NMVP and community groups more accessible for all. NMVP staff said the personalised care and support plan and information for new mothers was evolving to provide information on options and choices for people of all backgrounds and ethnicities.

The NMVP took part in monthly LMNS operations days. This provided communications with commissioners and the regional lead midwife. Staff reported a “fantastic network with them and easy to access them”.

The service offered wellbeing support to women and birthing people including information on how to access the mental health team, the Flourishing Babies team which offered antenatal support and baby care programmes, Strong Start team working to support new families alongside other local health services, MNVP, Milk & You a service pf peer support volunteers and parent befrienders trained to offer guidance on infant feeding. The MUM support team offered “help with stopping smoking and other stressful life events”. Smoking cessation support was also available for partners. Midwives specialised in providing guidance in safe physical activity in pregnancy. Other information available included vaccinations, nutrition, and recipe ideas.

Leaders developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said this helped them understand the issues and provide better care. Leaders had worked to encourage staff to record a person’s religion during their antenatal care and in September 2023 staff compliance had improved to its highest rate at 90%.

Minutes from the Obstetrics and Gynaecology Governance and Business Operational meeting showed leaders looked at themes from patient experience exercises. The professional midwifery advocate was allocated 60 hours for sessional duties for example providing restorative supervision for midwives and facilitating birth reflection sessions for mothers who experienced traumatic events during childbirth. The September 2023 report showed that 11 mothers had attended birth reflection and reported themes like not feeling listened to during birth, and feeling disempowered and unsupported on the postnatal ward, which is a known theme across all maternity services.

We received 6 responses to our give feedback on care posters which were in place during the inspection. Of these responses 4 were mixed with some positive and negative comments, 2 were negative, and none were positive only. Themes included delays in care, lack of information and support from staff, rude and unhelpful staff, and staff unable to manage the workload.

Maternity

During the inspection we spoke with 9 women and birthing people and 3 birthing partners and or relatives. All described very positive experiences, spoke highly of the whole maternity team, and had felt supported throughout their stay. People described midwives as attentive, caring, kind, and empathetic, listening to what they needed. People and their partners said staff, including doctors from theatre to the ward were very dedicated, assuring, supportive of partners' involvement, and included them in discussions.

Learning, continuous improvement and innovation

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

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

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

The Delivery Suite lead obstetrician held the role of fetal surveillance lead and attended a monthly regional fetal monitoring meeting, where each maternity service presented a case. This provided an opportunity to discuss issues and opportunities. They cascaded learning back to the unit.

Outstanding practice

We found the following areas of outstanding practice:

- Kettering General Hospital received a national award from a mother and baby charity for outstanding staff safety training work, before, during and after the Covid-19 pandemic. The charity said that it found that the trust had showed a 'tremendous commitment to safety training even during the height of the pandemic. Staff continued to attend safety training wearing restrictive personal protective equipment (PPE).
- On international day of the midwife in May 2023 the hospital hosted a Northamptonshire Midwifery Conference which showcased a host of improvements that had been made trust wide. During the event leaders showcased examples of quality improvement, such as its national pilot on supporting bereaved families, establishing a pre-term lead midwife and clinics to support mums likely to have premature babies.
- The service introduced the 'SCORE' survey in August 2023. SCORE stands for Safety Culture, Operational Risk, Reliability/burnout, and Engagement. Through a series of short questions, the survey aimed to assess aspects of our local team culture, including safety, communication, and teamwork. The initial audit showed a score of 31%. Leaders completed daily walkarounds of the unit to encourage staff to complete the survey with a final response rate of 64%. The next stage of the plan was to target community teams and new doctors who commenced in August to encourage completion. Regular communications were also being sent out to staff via email and closed social media.

Maternity

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 service MUST take to improve:

Maternity

- The service must ensure the design, maintenance and use of facilities, premises and equipment meet requirements to keep people safe. Regulation 12 (1) (2) (a) (d)
- The service must ensure staff complete daily checks and correct provision of emergency and specialist equipment. Regulation 12 (1) (2) (a) (d)
- The service must ensure a safe and effective triage process that includes risk assessment and a prioritisation for all women and birthing people attending triage, to identify those most at risk so that they can be assessed within safe time frames. Regulation 12 (a) (b)
- The service must ensure that staff complete all documentation including waiting times and risk assessments using a recognised prioritisation tool for all women and birthing people attending triage. Regulation 12 (a) (b)
- The service must ensure staff complete and document a risk assessment at every CTG. Regulation 12 (a) (b)
- The service must ensure medicines are stored correctly and emergency medicines are immediately available to staff on all wards and treatment areas to ensure safe care for women, birthing people, and babies. Regulation 12 (2) (f)
- The service must ensure the grading of incidents accurately reflects the level of psychological and physical harm experienced by women, birthing people, and babies. Regulation 17 (1) (2) (a) (b) (e) (f)
- Staff must ensure correct patient ID information is used at all times. Regulation 12 (a) (b)
- The service must ensure there are effective governance processes and systems to monitor progress, and manage identified actions and improvements to reduce the recurrence of incidents and harm. Regulation 17 (1) (2) (a) (b) (e) (f)
- The service must ensure there are sufficient suitably qualified, competent midwifery staff to deliver the service in line with national guidance, including but not limited to a staffing template review. Regulation 18 (1)
- The service must ensure there are sufficient suitably qualified and competent medical staff to deliver safe care for maternity triage and elective caesarean section (LSCS) lists. Regulation 18 (1)
- Leaders must ensure consistent management across all areas to ensure performance levels are maintained, and staff concerns are heard and acted upon. Regulation 17 (1) (2) (a) (b) (e) (f)
- The service must ensure Duty of Candour is carried out in a timely way. Regulation 20.

Action the trust SHOULD take to improve:

- The service should agree and ensure one method is used to document cleaning and equipment checks.
- The service should ensure NEWTT assessments are audited to identify whether guidance is followed and escalation of any deterioration is carried out effectively.

Maternity

- The service should develop a vision for what it wants to achieve with a strategy dedicated to maternity to turn it into action, developed with all relevant stakeholders.
- The service should ensure the culture supports all staff to feel respected, supported, and valued.

Our inspection team

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