Harrogate and District NHS Foundation Trust

Harrogate District Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Harrogate District Hospital

Good

The first 2 pages of this report pertain to the hospital location, from page 3 the report focuses on the maternity service.

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

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 did not change the rating of the hospital at this inspection. The previous rating of good remains.

How we carried out the inspection

During the inspection we spoke with 20 staff members, and 9 patients. We reviewed 26 patient records and medicines charts and 10 policies.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 19 feedback forms from women. We analysed the results to identify themes and trends.

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

Maternity

Requires Improvement

We rated maternity services as requires improvement because:

- Compliance with appropriate safeguarding, life support training and medicines did not meet targets, however there was a plan in place to recover this position. Regular checks on life saving equipment were not always completed. There was no clear system in place to identify prioritise risks to women in the maternity assessment area and there was no record of time to be seen, however, following inspection an action plan has been developed. Medical staffing numbers were not always sufficient, however there were mitigating actions in place.
- Information systems were not always appropriate for the service, however, there was a plan in place to improve this. The service was developing a vision for what it wanted to achieve and strategy to turn it into action. Governance processes were not always robust and there was limited embedded audit in the service.

However:

- The service had enough midwifery staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women in most areas, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent for their role. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed appropriate life support training for their role.

Staff did not always receive and keep up to date with their mandatory training. The trust target for mandatory training was 75%. Data provided as part of the inspection showed nursing and midwifery staff showed compliance for the 8 mandatory core training modules had been met or exceeded the trust target. For the 26 role specific mandatory training modules, data showed the training compliance had been met or exceeded the trust target in 12 modules and 14 had not been met. For the 7 specific maternity training 4 of the modules had been introduced in October 2022 out of the 3 remaining modules training compliance had been met in 2. During the factual accuracy process the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Maternity

Data provided showed medical staff compliance for the 8 mandatory core training modules had not met the trust target. For the 17 role specific mandatory training modules, 4 had been met or exceeded the trust target and 13 had not been met. For the 6 Specific maternity training 4 of the modules had been introduced in October 2022, both remaining modules showed medical staff training compliance had met or exceeded the target. During the factual accuracy process the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Sixty per cent of midwifery staff had current adult basic life support with paediatric modifications training. None of the eligible medical staff members had completed advanced life support training and 30% of medical staff had current adult basic life support with paediatric modifications training. This meant that service leaders could not be assured staff had the correct skills and knowledge to safely treat patients who required lifesaving care or treatment. During the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Staff had not all completed appropriate advanced life support and neonatal advanced life support training. The trust target was 75%; midwives in the acute hospital had completed neonatal resuscitation training; compliance was 95%. However, medical staff compliance was 33% and nursing and midwifery support staff compliance was 67%. This meant that staff did not always have training to provide lifesaving treatment to women and babies in their care. During the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

We asked the trust to provide training data for birthing pool evacuation. The service had a policy for using the birthing pool during labour, however there was no specific training module in staff mandatory training, and the policy stated the training was provided to reflect guidelines changes, or when audit, monitoring or incident reporting identified deficiencies in practice. We asked staff during the inspection about the last time there had been a pool evacuation drill and staff could not tell us. The was no clear mechanism for ensuring staff were trained and competent to evacuate patients from the pool in an emergency situation.

Staff completed regular skills and drills training. Records showed staff completed emergency skills training annually, including sepsis, cord prolapse and eclampsia and drills training on scenarios such as shoulder dystocia, maternal collapse and intubation and ventilation. Compliance against the trust target of 75% was 84% for medical staff and 91% for nursing and midwifery staff in maternity services, which was above the trust target.

The mandatory training programme was comprehensive and met the needs of women and staff. Staff told us training was delivered in a multidisciplinary (MDT) way and training was adapted to incorporate learning from incidents and wove throughout the training human factors which were identified during the incident investigation. There was a multidisciplinary approach to planning training as there was a lead consultant for training which demonstrated leadership by example. There was a policy for the provision of multidisciplinary training within maternity services including the training needs analysis and learning development plan; it was version controlled and in date and reflected the training requirements for each role required.

Mandatory training development was led by a practice development midwife and a consultant obstetrician which demonstrated the importance of multidisciplinary training for all grades and disciplines of staff.

Maternity

The service provided training and competency based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Nursing and midwifery staff compliance was 95% in both acute and community services. Medical staff compliance was 100%. All staff groups met the trust target of 75%.

The service provided protected time for newly qualified midwives one day a month to consolidate their pre-registration training. All newly qualified midwifery staff we spoke with valued this time.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. However, not all staff were trained on how to recognise and report abuse.

Staff did not always receive training specific for their role on how to recognise and report abuse. The trust target for safeguarding training was 75%. Medical staff overall compliance with safeguarding children training targets was 55% and 73% for safeguarding adults training. This did not meet the trust target, however, during the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Nursing and midwifery staff compliance with safeguarding children training targets was 59% which did not meet the trust target and 81% for safeguarding adults training which exceeded the target. During the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved for safeguarding children level 3 in line with the action plan.

Support staff/unregistered nursing staff compliance with safeguarding children training targets was 90% for level 2, which exceeded the target.

The service had a named safeguarding midwife who provided advice and support to staff regarding any safeguarding concerns identified. We saw safeguarding concerns were also shared during handovers between staff.

Level 3 safeguarding children training was provided to staff in line with national intercollegiate guidelines (2019), however safeguarding adults level 3 training was not provided to any staff role; this was not in line with national intercollegiate guidelines.

The service had a safeguarding action plan which identified training provision, including appropriate levels of training as a risk, the original target date for all levels of training was 31 January 2023. However, during the factual accuracy process the trust provided the final plan which showed an updated date for completion for a final action on 31 March 2023.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service offered training specific for staff roles on how to recognise and report abuse. The safeguarding children's level 3 training covered the expected areas, including scenario based reviews and personal reflections, The training was completed remotely as a workbook with an online reflection session.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We found examples where safeguarding concerns were acted on during the inspection and in patient records we reviewed.

Staff had training on how to recognise and support women who had experienced female genital mutilation and knew how to raise concerns when and if required.

Staff followed the baby abduction policy and undertook baby abduction drills. The service had recently completed a live baby abduction drill which was good practice.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were generally clean and well-maintained, however we saw isolated incidents of damaged soft furnishings and grab rails, which meant they were not wipe clean.

Cleaning records were up-to-date in ward areas and reported that all areas were cleaned regularly. The service audited cleaning checks weekly. The trust provided audits for the weeks commencing 10, 17 and 24 October 2022 and these were completed in full. During the factual accuracy process the trust provided the cleaning audits for the weeks commencing 31 October and 7 and 14 November 2022 and these were also completed in full.

Staff followed infection control principles including the use of personal protective equipment (PPE).

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

The service had processes in place to manage cleanliness and infection control, however we did not see these were completed in all areas, or in a timely way. We did not receive any audit information for the antenatal clinic. We reviewed the infection prevention and control audit outcome between 01 August and 31 October 2022; there had been 3 audits in the time frame on the delivery ward and 2 on Pannal ward and maternity assessment unit. On the delivery ward, compliance averaged 99% across the three months, however the audit deadline was met only 1 in 3 times, which meant it was not always completed in a timely way. There had been no environmental audit on Pannal ward in the timeframe, however, there were 2 cannula insertion audits; compliance was 90% on average across both completed audits, one had been missed in the timeframe.

On the antenatal clinic, we did not see evidence of daily cleaning records. We asked staff but they were unable to provide audits or cleaning records for this area. We found curtains in the antenatal clinic were not dated, so it was unclear how long they had been hung, or when they were due to be changed; they appeared clean. We were not assured there was sufficient oversight of the cleaning that took place, although the department was clean. However, during the factual accuracy process the trust provided cleanliness audit results for antenatal clinic between January and October 2022 which showed scores between 96.8% in May 2022 and 100% in all other months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, regular checks on lifesaving equipment were not completed in line with trust policy.

Women could reach call bells and staff responded quickly when called.

Staff did not always carry out daily safety checks of specialist equipment. We found a number of gaps in daily and monthly checklists for emergency trolleys and resuscitaires across different areas of the service. On one ward, we found daily checks were completed on 11 out of 31 days. We saw gaps in monthly checks of the contents of adult resuscitation

trolleys on the delivery suite; which had not been documented since January 2022 and antenatal clinic; which had not been documented since March 2022. On 1 trolley we found an item which was identified as missing during a routine audit in August 2022 and was found to be still absent during our inspection, we escalated our findings to staff and the item was replaced. We saw gaps in checks in every month from July to the date of the inspection.

We also found on Pannal ward the obstetric emergency trolley had not been checked 49 out 79 days between 01 September and the date of our inspection on 15 November 2022. In addition, the flow chart for the management of postpartum haemorrhage was out of date and was not aligned to the current policy. This was a risk to patients because the ward staff could not be assured that all emergency lifesaving equipment was available in an emergency situation, and leaders had not identified that there were significant gaps in equipment checks.

We asked ward managers about daily checks on emergency equipment and they told us they were regularly checked by managers and checks were completed appropriately, but this was not in line with what we found.

We checked the fridges for storing patient food and found gaps in temperature checks on the delivery suite between August and November 2022. We also found out of range readings, and these were not always rechecked in line with the trust policy.

The service had suitable facilities to meet the needs of women's families. The environment was suitable, including mood lighting, birthing equipment and appropriate décor. There was a bereavement suite away from the main labour ward area which was appropriately decorated with access to memory boxes and support for patients and their families.

Staff disposed of clinical waste safely. We found waste was appropriately disposed of and sharps boxes were completed in line with guidelines during the inspection.

Assessing and responding to patient risk

On ward areas, staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, there was no clear system in place to identify prioritise risks to women in the maternity assessment area.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately on the ward areas. The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in detecting the seriously ill and deteriorating. The MEOWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016). The trust provided evidence which showed there was a clear process of monitoring and escalation of women’s health and wellbeing.

The service had a maternity assessment centre where women could telephone for over the phone advice from a midwife and if needed, or requested, attend the department for clinical review. The service had two different triage systems; one was a RAG rating (red, amber green) system which provided timescales that women should be seen, depending on the urgency of their concern or symptoms and the other was an acronym, CUSS, which stood for "I am Concerned, I am Uncomfortable, This is a Safety issue, Stop". We did not find evidence of triage categories or prioritisation given to

women who used the service in the 8 patient records we checked in this area, and when we asked the trust about audits of the triage tool, however none were available. This was a concern as there was no robust assurance mechanism in place to check that women were appropriately triaged, seen by a clinician in an appropriate timescale, and seen in order of clinical need.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Cardiotocography (CTG) used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. When we looked at patient records, we saw that CTG documentation was documented in line with national guidance. The service did not undertake formal CTG audits, however, CTGs were reviewed as part of the professional advisory panel (PAP) and any findings of these reviews were fed back to individuals or communicated to the wider team. However, this meant CTGs which did not meet the threshold for review in PAP were not audited.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. We asked the trust to provide audits of the WHO surgical safety checklist, including findings and actions taken to make improvements. We observed the completion of surgical safety checklists during the onsite inspection and did not find any concerns, audit data between August and November 2022 also confirmed this.

Staff knew about and dealt with any specific risk issues. We found staff discussed patient's holistically during handovers and made appropriate referrals or signposting to provide support to women.

We found staff completed risk assessments for each woman on admission / arrival, using an assessment of risk tool, and reviewed it regularly or after any incident. We found SBAR (Situation, Background, Assessment, Recommendation) tools were used in patient records to handover key information and the same tool was used for shift handovers. The service had not completed any SBAR audits although provided information which showed they were reviewed as part of the PAP review process. This meant SBARs which did not meet the threshold for review in PAP were not audited.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health).

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. The service used SBAR to handover key information. We saw this was documented in patient records.

There had been no pool evacuation simulation since prior to the COVID-19 pandemic. This was a risk because training was only delivered on induction and if there was an identified need, so the service could not be assured staff were competent and confident to evacuate a birthing pool in an emergency situation.

We reviewed the service's maternity quality dashboard. The dashboard provided target figures to achieve for some indicators, however it did not benchmark against national indicators. There was no clear system to use the dashboard as a benchmarking tool, as national figures were not included. Leaders we spoke with told us that the dashboards

required some development to help identify key themes and trends in a timely way. Leaders stated the introduction of an electronic patient record system would support a more effective maternity dashboard. The dashboard did not include information including sepsis, time from decision to knife to skin or different volumes of post-partum haemorrhage.

The service used the local, regional, and national maternity dashboards collectively to report on clinical outcomes such as mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (cot acuity, preterm delivery), public health information and statistical analysis. It also covered data in regional and national dashboards such as the monitoring of induction of labour. The service provided the local quality dashboard, which included workforce and unit closures, however, this had not been completed in any month in 2022. There were gaps across the dashboard that had not been completed or used. During the factual accuracy process, the trust provided additional information which showed where workforce and unit closures were discussed and monitored.

The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service made sure staff were competent for their roles through an appraisal.

The service had enough midwifery and support staff keep women and babies safe.

The most recent birthrateplus® report from April 2021 showed the service had enough trained midwifery staff. The vacancy rate was low and evidence provided at the time of the inspection showed the total vacancy rate in both midwifery and midwifery support staff was 5.78 whole time equivalents (WTE) overall.

The service managed staffing well, A red flag event is a warning sign that something may be wrong with midwifery staffing of the flow across the maternity unit. There had been 1 red flag event on delivery suite and 22 red flag events on Pannal ward in the last 6 months. There were 13 red flags reported due to delays between admission for induction and the beginning of the process, however there were 3 delays in care, 4 delays in providing pain relief and 1 delay in recognising or acting on abnormal vital signs. We spoke to ward managers about how these events were managed and were told that priority was given to providing one to one care to women in labour on delivery suite. Most instances of short staffing were due to short notice staff sickness or absence. Staff moves did not impact on care delivery on the joint antenatal and post-natal ward.

We looked at the most recent staffing report sent to the trust's board which reported midwifery staffing and absence and planned versus actual staffing in the maternity departments. There was an identified gap in the bereavement midwife position. Staffing was regularly reported to board level, and we saw that actions were taken to mitigate staffing shortfalls both in the short and longer term.

Sickness rates for non-medical staff were 6.55%.

Maternity

There were 14.65 WTE midwives in post in the community, against an establishment of 9.9 WTE midwives. This was in preparation for the roll out of the national continuity of carer, however, this was on hold. Community midwives were integrated into the acute workforce and were also utilised during the day as part of the surge process. There were also 3 WTE maternity support workers in the community to support the delivery of care for women outside of hospital.

There were 3 administrative staff to support the antenatal clinic and 0.6 WTE administrative staff for the screening service. Across Pannal ward and the delivery suite, there were 1.5 WTE administrative staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Managers supported staff to develop, however yearly, constructive appraisals of their work did not meet the trust target. Overall, the maternity services achieved 86% of appraisals completed; Compliance for midwifery and maternity support works was staff was 87%. This meant that most staff in the maternity service had received an appraisal in line with guidance and best practice and supported staff in their training, learning and development.

Managers made sure staff received any specialist training for their role. There were 11 specialist midwife roles; 7.86 WTE band 7 specialist midwives were in place and two 0.5 WTE band 6 roles, who were awaiting a start date, to support women in different areas including infant feeding, bereavement, a digital midwife and fetal wellbeing lead. However, 8 of the specialist midwife roles did not relate to specialist clinical provision, for example, there was no specialist midwife to support women with diabetes, perinatal mental health needs, substance misuse or to support teenage pregnancies.

Medical staffing

The service had enough medical staff most of the time with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment, however there were plans in place to mitigate risk and improve staffing.

The service had enough medical staff most of the time to keep women and babies safe.

We reviewed medical staffing numbers which included forecasted medical staffing numbers which would not meet the ideal staffing for the period December 2022 to February 2023. We saw there was the correct number of consultant staff. However there ongoing staffing issues to fill the junior doctor rota which was on the trust risk register. Leaders told us they had a recruitment plan in place and the board report reflected forecasted improvements to the obstetric staffing numbers from March 2023. We saw improvements in provision between the board report in May to September 2022, where the gaps had reduced from 4 middle grade vacancies to one.

Sickness rates for medical staff were 5.51%.

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. The service used locum medical staffing to fill rota gaps; this supported the out of hours rota gaps that had been a long standing staffing concern in the service.

The service always had a consultant on call during evenings and weekends. Staff told us consultants were available to call for support when they were off site, and they had no concerns with attendance if needed.

Managers supported medical staff to develop however yearly, constructive appraisals of their work did not meet the trust target. Compliance for doctors was 75%. This meant that most staff in the maternity service had received an appraisal in line with guidance and best practice and supported staff in their training, learning and development.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, records audits were not completed and there was no system in place to document triage assessment and prioritisation outcomes in the maternity assessment centre.

Women's notes were comprehensive, and all staff could access them easily. We reviewed 19 patient records and records were completed in line with trust processes.

When women transferred to a new team, there were no delays in staff accessing their records. The service used paper records and had administrative support to access notes for clinics or assessment. Patient notes were stored in an accessible area to staff during their pregnancy.

Records were stored securely.

However, the service did not document or audit the use of a triage tool in the maternity assessment centre and there was no clear system for this information to be documented.

We asked the trust to provide audit data for patient records for the last 6 months; the trust had no audit available to provide. During the factual accuracy process the trust provided an action plan they had developed following the initial trust feedback to demonstrate they were implementing an audit of triage records and processes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff training in medicines did not meet the trust target and competency checks were infrequent.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records accurately and kept them up to date. We reviewed 7 patient medicines records and found they were mostly complete, however patient weights were not recorded in any of the records we looked at. This meant staff could not be sure they were appropriately prescribing medicines based on the weight of the patient.

Staff stored and managed all medicines and prescribing documents safely.

Overall compliance with medicines management training targets was 60%, we were told this was due to disruption of the training programme during the pandemic. This did not meet the trust target. Medical staff average compliance with the two required medicines management training targets was 48%, with one module at 28%. Nursing and midwifery staff average compliance with the two required medicines management training targets was 64%. This did not meet the trust target.

The service did not have effective systems in place to check staff competency when using medicines was in line with trust policy and national guidelines. We saw 53 out of 79 staff had been reviewed and signed off as competent, and 6 staff were not authorised to give intravenous (IV) medicines. However, there were effective plans in place to improve this position.

Maternity

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they felt comfortable raising concerns and felt listened to. We heard examples where staff thought incidents were managed well.

The service had no never events on any wards.

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

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Most incidents were investigated and responded to in a timely way; however, there were 2 serious incidents showing as open over 60 days. One from April 2022 was being investigated by an external body following the timely trust investigation. The other from July 2022 was investigated within the time period but was delayed from closure by needing additional sign off as agreed with the local integrated care board and communicated to the patient.

The trust held 48 hour review panel discussions to discuss initial findings relating to incidents. We looked at two recent reviews and found they considered the expected areas, including if the serious incident framework criteria was met, immediate learning and actions and any specific areas to be included in the terms of reference. However, we found relevant sections of the record were not completed, for example no colleagues were recorded as present in one report, no learning or immediate actions had been documented for either incident and one report had no panel date recorded.

In the last 6 months, 3 incidents were referred to the Healthcare Safety Investigation Branch (HSIB) for investigation; one did not meet the HSIB threshold and was returned for investigation in line with local policy, one was ongoing, and the third had recently been completed. We reviewed recommendations from the completed HSIB investigation; however, the trust did not provide its related action plan. Recommendations related to appropriate supervision for medical staff in training and categorisation and escalation of cardiotocography interpretations.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was a weekly labour ward forum where incidents were reviewed as a team and staff were made aware of themes or trends.

Staff met to discuss the feedback and look at improvements to the care of women.

The service had not reported any neonatal or post-natal deaths from 01 May to 14 November 2022. There were 4 perinatal deaths and the trust reviewed their care by a multidisciplinary team approach who used the Perinatal Mortality Review Tool. We reviewed the perinatal mortality tool for this time frame for the one completed case and saw it was completed fully.

Managers debriefed and supported staff after any serious incident. Staff had access to Professional Midwifery Advocates (PMAs) and the trust offered online access to this service.

Maternity

The service used themes and trends from incidents to inform upcoming training days which were delivered in a multidisciplinary approach; this meant the service had embedded a learning culture into the system.

Is the service well-led?

Good

We rated well led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles. There were clear lines of escalation and oversight from executive leaders.

There was a new leadership structure in place across the trust and roles were being appointed to during the inspection period. We heard about how the new structure would work, and it included clear lines of reporting, dedicated non-clinical time to attend regular meetings and clear roles and responsibilities.

The service was led by an associate director of midwifery, operations director and clinical director. The triumvirate was supported by a maternity services matron, ward manager/coordinators, specialist midwives and a lead midwife for risk and clinical governance. While individuals were relatively new in post, the structure had been established for some time and was well embedded and understood. There was a clear line of reporting into the executive directors and board. There was a governance group in place and regular directorate governance meetings were held. Relevant information was escalated to the trust quality and safety committee.

Leaders told us they felt supported and had direct access to the board level executive and non-executive director safety champions, as well as regular bi-monthly meetings where risks and issues were escalated. Staff told us leaders were approachable and visible.

The service leaders had links with the Maternity Voices Partnership (MVP) and during the inspection we spoke with the MVP chair; despite issues outside of the trust's control, trust leaders, safety champions and the MVP had developed good relationships and spoke about ambitions for service user voices driving forward changes and improvements.

Mandatory training development was led by a practice development midwife and a consultant obstetrician which demonstrated the importance of multidisciplinary training for all grades and disciplines of staff.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, however leaders had plans in place to develop one.

The service was developing its current strategy, but this was behind schedule. As part of the trust's maternity self-assessment action plan, the development of a strategy had a target completion date of January 2023. Leaders told us that the overarching trust strategy had been developed with an overarching ambition for high quality maternity services, with confidence of women and families. Service level leaders were in the process of developing the service level

strategy to link to trust wide objectives. They told us staff would be involved in the co-production but did not describe how they would involve staff in the development of a vision and strategy for the service. The focus was on trust-wide ambitions relating to the best start for children across the footprint of the trust, which included a large geographical area of community services.

The maternity unit had an overall improvement plan which was being used to steer the unit; this was monitored monthly by the safety champion and triumvirate group and any issues escalated at board level monthly. Issues noted included the turnover of leaders in the last year. Leadership roles had been appointed in the new management structure; they had not had time to embed in the service at the time of our inspection. Senior leaders and managers articulated their top priorities for the organisation, which linked to their ongoing plans. These areas were consistent with the gaps we found during the inspection. They included the following:

- Changes to the local population meant the service had recognised a need to engage with the Ukrainian community with the Maternity Voice Partnership (MVP), and joint working had commenced in this area.
- A need to increase the safeguarding specialist midwife role from 0.5 WTE to 1 WTE role. This was anticipated to reflect in addressing safeguards more swiftly and auditing for any trends to inform practice changes or training.
- Recruitment to the mental health midwife vacancy.
- To introduce an electronic patient records system; this was planned to roll out from January 2023.

We found these areas were all in progress and had been identified as risk factors in managing the maternity unit.

Culture

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

Staff we spoke with felt there was an open culture; they could speak up about concerns and they felt they would be listened to. In the July 2022 staff survey, 73% of staff felt able to make suggestions about their work and the same percentage felt they had opportunities to show initiative. The survey also reflected 93% of staff witnessed and experienced teamwork.

Staff felt there was a no blame culture, and this encouraged conversations or the opportunity to raise any issues. Staff felt the senior management team were visible and they felt able to contact the consultants directly if required. When investigations were completed there was an inclusive approach through a round table format enabling staff to talk as a group and feel supported.

We saw positive and caring interactions between staff, and with their patients. All midwives and staff we observed were friendly and supportive.

The staff survey dated July 2022 also identified areas for improvement. For example, due to staffing shortages, staff responding to the survey said they did not always feel supported to develop their roles or feel supported with their wellbeing needs. These themes had been responded to, with the appointment of a Band 7 midwife to support retention and staff support. Staffing was reviewed regularly using an acuity tool and the actions to maintain numbers to meet the needs of patients was discussed regularly with staff.

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A further survey completed in September 2022 focused on themes around staff wellbeing. The survey showed 53% of staff, felt there could be an improvement in their wellbeing. The Professional Midwifery Advocate (PMA) introduced 'Wellbeing Wednesday' which was open to all midwives and doctors to offer support and information. Staff we spoke with felt this was supportive and staff looked forward to the weekly emails which offered support and offers available within the hospital services or NHS offers.

Women, relatives and carers knew how to complain or raise concerns. The service received no complaints in the 3 months before the inspection. We reviewed complaints from previous months and found they had been addressed. One area which had been identified was communication and a range of options were being considered to improve this area along with opportunities to provide feedback.

Oversight of safety in maternity services was reported to the board monthly. We reviewed the last 2 reports and found appropriate risks and issues and key challenges were escalated, and they were reflected in other reports we reviewed.

The maternity and neonatal safety champions met 4 times in the 7 months prior to our inspection. We reviewed the meeting minutes for the April 2022 and found there was a focus on safety, staffing and national improvement schemes and initiatives. Board safety champions told us there were informal opportunities for safety champions to meet with them or raise concerns.

As part of the national maternity inspection programme women and birthing people are asked to provide feedback on care. Of the 2,226 women and birthing people contacted 19 chose to provide feedback about their maternity care at Harrogate District Hospital. Most praised staff attitude with 12 containing positive responses about the care they received from staff. The concerns raised by some women included delays experienced and some issues with being listened to and fully supported.

Governance

Leaders did not always operate effective governance processes. Systems to embed learning from the performance of the service into improvements were in their infancy. Policies and process used were not always up to date. However, staff were clear about their roles and accountabilities in the new structure

There was a new leadership and governance framework in the service which had only been implemented fully in the weeks before our inspection. The maternity risk management strategy set out the governance structure for the maternity services. Roles and responsibilities were clearly identified in the policy, including responsibility for reviewing incidents at all risk levels. Staff and leaders could clearly articulate this new governance framework for the directorate and how information flowed between maternity services and the board and were clear on their roles in the new structure. However, the structure was not embedded and the evidence we reviewed was in line with the old structure. The new structure had not been in place for enough time to comment.

Staff did not always have access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We found a number of policies and flow charts in the that were not dated, or version controlled, or which had passed the review date during the inspection. There were also sections of guidelines with differing versions and review dates printed together in reference folders in the service.

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues. There were clear links to the Local Maternity and Neonatal System (LMNS) and local system.

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Serious incidents were discussed in the local maternity system, including incidents referred to HSIB. Meetings were held monthly and included peer reviews, trust presentations of incidents across the local area and a local learning log which supported shared learning across trusts.

Senior leaders in maternity services met, however we did not see that formal meetings were regular. We asked the trust to provide the last 3 meeting minutes and they provided 2; the senior management team for maternity services met in June and October 2022. There was no set agenda and the minutes covered high level updates. In the most recent meeting, we did not see evidence of discussing themes, incidents, learning or any actions identified.

Internal meetings were not always held regularly. Clinical governance meetings were held bi-monthly. We looked at meeting minutes for the last 3 meetings; they covered topics including safety concerns, incidents, training, feedback, risks, issues, and learning. However, the meeting in July 2022 had not gone ahead, which meant there was a four-month gap between meetings. We saw that low training compliance was discussed at the most recent meeting. However, we did not see that issues we identified during the inspection had been identified through the assurance systems in place, for example out of date guidance and lack of audits. We were not assured that the governance mechanisms were supported by effective assurance systems to identify issues and concerns to be actioned.

The service was represented at the monthly local maternity system serious incident peer review panel where serious incidents were discussed, and actions taken at local area level. Learning was identified and updates were provided on ongoing reviews. During the factual accuracy period the trust provided evidence that serious incidents were discussed as part of the wider directorate.

Following the publication of the Ockenden report (2019) the service completed a benchmarking exercise. We looked at the outputs of the assurance visit in June 2022 relating to the first Ockenden report. We looked at the outcomes of the exercise and associated action plan and found there were 12 areas of positive findings. These included, the environment, quality and effectiveness of multidisciplinary training, effective baby abduction policy, new posts to support the service and positive MVP involvement in service improvements. The service was compliant with the 7 immediate and essential actions. However, the review identified a recommendation, to strengthen governance and audit processes.

The service had 1.2 WTE practice development midwives in place. They were responsible for monitoring and managing staff training schedules. There was a training matrix, and 15 training requirements were developed from local and national drivers and requirements. The training plan also linked to further resources for further reading on some modules.

The service last completed a staffing and acuity review in April 2021 for midwifery staff. It said the service needed 76.21 whole time equivalent staff (WTE) across maternity services to meet the planned needs of women. The service had some vacancies and were addressing this by advertising to over-establish on some roles in order to back fill areas that were difficult to recruit to. There were rota gaps in the middle grade medical rota which had been addressed by recruiting long term locum cover. The service had a plan in place to recruit to vacant posts and it was on the service's risk register.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. There was limited embedded audit in the service, and we were not assured systems were in place to support improvements.

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The service had a risk register in place. We reviewed the risk register and saw one risk scored at 12 which was RAG rated red, 4 rated 6, on rated 8 and one rated 9 which were RAG rated amber, and one rated 4 which was RAG rated green. We found the risk register had clear, regular updates and evidence of risk scores reducing. All risks were progressing within the risk reduction target timelines set by the service.

The trust had a maternity risk management strategy. It was in date and due for review in April 2024. The strategy was clear and included risk escalation and management of incidents, risks, and the governance and meeting structures to support the flow of information. The strategy included incident reporting and escalation process for incidents, including serious incidents and never events and included the governance arrangements around low risk incident management, which was good practice.

There was a robust policy in place to manage the department when it was in escalation which was in line with the national Operational Pressures Escalation Levels Maternity Framework. The policy was based on 7 escalation triggers:

- Ward bed capacity
- Labour ward bed capacity
- Triage breaches
- Unable to give 1:1 care in established labour
- Birth rate plus activity and dependency score on labour ward
- Labour ward co-ordinator not supernumerary
- Delays in elective work includes induction and women booked for elective section.

We saw there were clear actions in place to mitigate risks and manage levels of staffing to the needs of patients, including timeframes for review.

In the last 12 months, suspension of maternity services had occurred 18 times. There had been 4 incidents of suspension of service between March and November 2022, and the 12 incidents prior were largely due to sickness and inability to provide 1 to 1 care to women in labour. The service reviewed all incidents and documented the action as appropriate. We saw in recent incidents the services were suspended for a short period of time which meant that the service re-evaluated the escalation regularly.

The service participated in relevant national clinical audits. The service provided evidence they complied with 3 out of 5 saving babies lives care bundle audits. We found that there were recommendations and outcomes linked to the audits and the service had developed action plans to respond to those recommendations in 2 of the 3 audits. Evidence provided at the time of inspection showed actions in the reduced fetal movements audit was due to be completed by October 2022. During the factual accuracy process the trust provided evidence that all actions had been completed by the required National deadline of December 2022.

We reviewed the trust response to a saving babies lives survey which collected information on the progress of trust progress towards the full implementation of the saving babies lives care bundle in October 2022. The service identified 2 areas in which they had not met the requirements, however, plans were in place which included carrying out improvement activity to reduce smoking in pregnancy and recording of reduced fetal movements. Staff we spoke with identified the planned the introduction of an electronic patient record system, due to commence in January 2023, would enable compliance with reporting requirements they were currently unable to meet.

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We reviewed the trust's compliance with the perinatal clinical quality surveillance model and found perinatal clinical quality was reported through a monthly report to the trust board. The report included emerging challenges, risks and issues, staffing, risk and safety, service user feedback and national priorities.

Managers and staff did not always carry out a comprehensive programme of repeated audits to check improvement over time. The service had an audit programme in place; however, we were not assured there were robust mechanisms in place to check the quality and safety of care provided in the department. There were several audits that were not completed, including records, CTG documentation or fresh eyes, and audits of the triage system. We found the service intended to plan 23 additional audits on areas including completion of records, guidelines, and assessments, but there was no timescale identified to implement these audits and it was unclear how long they were being considered for action. This was a risk because the service did not have established systems and processes in place to support identifying issues, themes, and trends in care delivery to support improvements.

However, we did see completion of some expected audits. The new-born and infant physical examination (NIPE) screens babies for specific conditions, ideally within 72 hours of birth. The service audited the completion of NIPE examinations and achieved 97% compliance between 11 August and 10 November 2022. This meant they monitored screening and we found it was completed in a timely way.

We did not see evidence during the inspection of audits that provided assurance to leaders that policies and processes were followed. We asked the maternity services leadership team about ward-based assurance, audits or rounds and they told us there was a trust wide team who completed checks; however, they could not articulate how regularly they occurred or any recent outcomes. Ward managers we spoke to did not always have access to regular IPC audits or know if they were completed, however, the ward board for one ward contained results of hand hygiene, ward cleanliness and monthly audits. We found gaps in emergency equipment checks that ward managers told us were checked daily.

We were told that the service did not audit SBAR handover completion. There was no audit to monitor time taken to triage against the triage categories and service leaders did not provide additional information to assure us they took place.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with 4 out of 10 safety initiatives for the current year (year 4), and had documented plans in place to provide the remaining assurances required by the deadline of 05 January 2023. We reviewed the final report to board for year 3 from June 2021 and found they had provided sufficient evidence of their compliance to the trust board.

The service was accredited by united nations children’s fund (UNICEF) baby friendly gold award.

The trust evidence showed there were no actions required following the 2020 MBRRACE report. The service had an assurance visit in June 2022 relating to the first Ockenden report. We looked at the outcomes of the exercise and associated action plan and found there were 12 areas of positive findings, including environment, quality and effectiveness of multidisciplinary training, effective baby abduction policy, new posts to support the service and positive MVP involvement in service improvements. There were 7 immediate and essential actions the review identified and 8 recommendations, including strengthening governance and audit processes.

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Information Management

The service did not always collect and analyse reliable data. Staff could not always find the data they needed to understand performance and make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The service had a performance dashboard which collated data and insights about the service, however governance leads told us that updates were needed to streamline dashboards and ensure the outputs were useful in driving improvements.

Most patient records were completed on paper, and the service had delayed implementing some audits until the electronic paper records solution was implemented. This meant that the service was not always collecting and analysing data to make decisions, improvements and monitor care provided. There were plans in place to implement the electronic solution in 2023.

Ward managers did not always have access to information they needed, and we saw limited assurance audits taking place across the service; we did not see an embedded mechanism for collating audit information.

Data which was required by external organisations was collated and submitted in line with requirements.

Engagement

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

The service produced and circulated newsletters to staff. We looked at the last 3 editions and found they included incident and risk management information, performance overview, HSIB and internal incident investigation learning and feedback, staff support mechanisms and key facts relating maternity services.

We saw evidence which showed the service engaged with staff to support the maternity workforce strategy and antenatal education.

Maternity voices partnership (MVP) engagement meetings were scheduled bi-monthly and were scheduled up until November 2023. The engagement schedule also included service user coffee mornings to gain informal feedback and provide local support included.

MVP meetings were arranged in different times of the day across the year to provide opportunity to different groups to attend and included alternating morning and evening meetings. We looked at minutes and action plans from the most recent two meetings and saw there was representation from the MVP, trust and local people and organisations. Discussion and actions were driven by service users, service user engagement and seeking feedback to make improvements.

Learning, continuous improvement and innovation

All staff wanted to learn and improve services. There were areas of good practice which allowed staff to explore learning and service development.

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Improvements to the service were discussed at the maternity services forum which was held bi-monthly. We reviewed minutes from the last 3 meetings and found that improvements were discussed in response to feedback, incidents, or complaints. The group noted the need to become more proactive in service improvement.

Staff described a positive level of MDT training and support which was driven by learning from incidents. Human factors were built into the services whole training programme and staff were committed to providing scenario-based training which was measured through PROMPT (PRactical Obstetric Multi-Professional Training). When the service had staffing issues, mandatory training was not cancelled, and specialist midwives facilitated ward based training when staff could not be released.

The service provided dedicated time off the unit for band 5 midwives to complete their preceptorship. They received one day per moth bespoke training with additional pastoral support. This was good practice and had not been found in other units so far in the CQC national maternity services inspection programme.

The service had an online forum with another local trust for case discussion training in CTGs; staff could join from home remotely or watch after the stream.

The service was providing fetal head impaction training based on a live scenario and was the only regional service providing this training at the time of the inspection.

There was specialist support available to mothers; the service had an infant feeding coordinator with 4 days of protected time and midwives and midwifery support workers had received training in breast feeding.

Outstanding practice

We found the following outstanding practice:

- The service identified how all incidents should be managed in the maternity risk management strategy, including low risk rated incidents, and there were clear roles allocated to review all levels of incidents in the structure, which was good practice.
- The preceptorship programme to support newly qualified midwives included giving band 5 midwives a day out of clinical practice monthly. All band 5 midwives we spoke with valued this essential opportunity to reflect and consolidate their training.
- The service had implemented scenario based training in relation to the impacted fetal head. The training included a human factors approach which had seen an increase on the confidence of junior staff to challenge in emergent situations.

Areas for improvement

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

Action the trust MUST take to improve:

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- The service must ensure they embed a system of oversight for women attending the maternity assessment centre to prioritise their care appropriately and monitored. (Regulation 12 (2)(a))
- The service must ensure all equipment is checked and escalated if needed in line with local policy guidance and regulations. (Regulation 12 (2)(a))

Action the trust SHOULD take to improve:

- The service should complete all relevant documentation when incidents are reviewed.
- The service should continue to ensure staff receive appropriate support, training, professional development supervision and appraisal.
- The service should continue to embed systems to assess, monitor and improve the quality and safety of the services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors and one CQC inspection manager. There were two specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director for Secondary and Specialist Care.