North Tees and Hartlepool NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

North Tees NHS Foundation Trust provides acute and community health services to over 400,000 people in the immediate locality of Hartlepool, Stockton and parts of County Durham, as well as offering some specialist services more widely across the North East. There are two main hospital sites, University Hospital of North Tees, based at Stockton-on-Tees, and University Hospital of Hartlepool. The trust also operates a smaller, community hospital at Peterlee, and delivers community services at Lawson Street, Stockton, and One Life Centre, Hartlepool.

The trust provides urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children and young people's services, end of life and outpatient services alongside a range of community services delivered in people's homes and small community settings.

We carried out this unannounced inspection of North Tees and Hartlepool Hospitals NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the trust overall as good. Our inspection was prompted by concerns about the quality and safety of services. We also inspected the well-led key question for the trust overall.

We inspected maternity services at Hartlepool and North Tees hospitals, and services for children and young people at North Tees, from 3 to 5 May 2022.

We did not inspect medicine, surgery, urgent and emergency care, critical care, end of life care, outpatients or diagnostics at this trust during this inspection. We continue to monitor the quality of these services and may re-inspect if and when appropriate.

At this inspection, we found that ratings in maternity, had gone down to requires improvement since we last inspected them in 2018 when they were rated as good. At this inspection, we found the ratings in services for children and young people stayed the same, and we rated them as good overall.

Our findings

Due to the ratings given at this inspection, the trust's overall ratings of good across all domains changed to requires improvement in safe, effective and well-led. This meant that the trust's overall rating changed from good to requires improvement.

In rating the trust, we took into account the current ratings of medicine, surgery, urgent and emergency care, critical care, end of life, outpatients and community services including community health services for adults, children and young people, end of life and dental services which were not inspected this time.

At this inspection, we rated the core services of maternity requires improvement overall and services for children and young people as good overall.

Our rating of services went down. We rated them as requires improvement because:

- The trust had interim arrangements in place for several key roles, and there was a lack of united leadership and succession planning. Most strategies were in draft, incomplete and not complementary.
- Senior and executive leaders did not always operate effective governance systems to manage risks and issues within the service. Governance arrangements were complex and the board did not always have sufficient oversight and focus on operational risks.
- The trust did not have enough medical and midwifery staff in the areas we inspected to care for patients and keep them safe. Medical staff did not all have regular, up to date appraisals.
- The trust had not engaged with its local community to find out what people wanted and needed. Engagement strategies were not existent, or in development, and had not included consultation with the wider community, equality groups, the public or other local organisations.
- The trust did not always discharge its responsibilities fully under Duty of Candour regulations and did not audit compliance. Complaints were not being handled in line with the trust's complaints policy.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients and their families.
- Staff understood how to protect patients from abuse, and generally controlled infection risk well.
- Leaders and teams managed risk effectively and escalated risk where appropriate, and information systems supported staff to collect and store reliable data.

Outstanding practice

We found the following outstanding practice:

Trust wide

- The trust had set up a faculty of leadership and improvement in 2021 to support improvement across the organisation. This had the potential to embed the quality agenda across the organisation and increase leadership capacity but was not yet fully established.

Our findings

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:

Trust wide

- The trust must ensure effective operational oversight of risk, issues and performance. (Regulations 17(1) and 17(2)).
- The trust must strengthen the oversight of divisional and 'ward to board' governance. (Regulations 17(1) and 17(2)).
- The trust must ensure that it operates effective systems and processes for identifying, receiving, investigating and responding to complaints. (Regulation 16(2)).
- The trust must ensure that its respiratory unit meets current NHS guidance in relation to washing and toilet facilities. (Regulation 15(1)(c)).
- The trust must ensure that it complies with Duty of Candour regulations. (Regulation 20(1)).

Maternity

- The service must ensure that all care of women and their babies is undertaken in line with national guidance and best practice. (Regulation 12(1)).
- The service must ensure effective governance structures are in place to continually improve the quality and standards of care (Regulation 17(1) and 17(2)).
- The service must ensure systems are put into place to ensure staffing is actively assessed, reviewed and measures put in place to improve retention. (Regulation 18(1)).
- The service must ensure appropriate midwifery leadership is in place. (Regulation 17(1) and 17(2)).
- The service must ensure women who need additional care have access to appropriately trained specialist midwives. (Regulation 12(1)).

Children and Young People

- The service must ensure there are systems and processes in place to assess, monitor and improve the quality and safety of the services in respect of restrictive practices. (Regulation 17(2)(a)).
- The service must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. (Regulation 18(1)).
- The service must ensure that the Duty of Candour regulation is met in full for all notifiable safety incidents. (Regulation 20(2)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should continue to further develop its staff networks.

Our findings

- The trust should consider revising its strategies to ensure that they are up to date, consistent, and complimentary.
- The trust should consider addressing its Freedom to Speak Up literature to make it clearer that the guardian can be directly contacted as a first point of contact by staff in line with national guidance.
- The trust should ensure that its board papers are up to date and publicly available on its website at all times.
- The trust should ensure that policies and procedures are correctly managed and reviewed in a timely way so that the latest and most appropriate guidance is always available to its staff.
- The trust should consider auditing its application of Duty of Candour legislation regularly to ensure compliance.

Maternity

- The service should work with other trust services to implement baby abduction training.

Children and Young People

- The service should ensure that incidents are reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.
- The service should create and monitor action plans with clear actions, timescales and action owners.
- The service should ensure appropriate fire safety procedures and inspections are completed and records stored in line with trust policy.
- The service should ensure that equipment checks are completed in line with the trust's policy.
- The service should ensure that out of date medicines are disposed of in line with the trust's policy.
- The service should ensure that their policy and practice for the storage of expressed breast milk is in line with national guidelines.
- The service should ensure that there are appropriate facilities and reasonable adjustments made for children and young people and their families who are being treated on adult wards to make them comfortable.
- The service should ensure that they clearly document mitigating actions taken for each risk on the risk register and evidence they monitor and manage risks appropriately.
- The service should recommence simulation of child abduction to ensure their emergency preparedness.
- The service should continue to improve compliance with appraisal rates in line with the trust target.
- The service should improve compliance with infection prevention and control training modules to meet the target.
- The service should put plans in place to increase response rates to the NHS Friends and Family Test in the Children's Day Unit.

Is this organisation well-led?

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

Our findings

Leadership

Leaders did not always have the skills and abilities to run the service. They understood the priorities and issues the trust faced, however there were a number of interim appointments and vacancies impacting on the stability of the board and making maintaining operational oversight a challenge. Staff reported they were not always visible and approachable in the service for patients and staff.

At our previous inspection in March 2018 we rated well led as good. We reported that leaders had the experience and skills to deliver the trust's strategy and were knowledgeable about issues and priorities for the service. Leaders were visible and approachable, and morale across the services we inspected was generally good.

However, during this inspection, we found key posts vacant or filled on an interim basis, and that most of the Non-Executive board had changed within the last six months and since our last visit. Leaders talked about the loss of experience that this had caused, and this had had an impact on how the board was able to function. The Non-Executive posts had been filled on an interim basis but at the time of inspection, despite clear plans, recruitment to fill these posts permanently had not yet begun.

There was no succession planning for key executive posts, for example, the chief executive, chief nurse and medical director. During our inspection front line staff did not describe leaders as visible and approachable and morale was not always positive in the two core services we visited.

There was a clear disconnect and difference in views around the board leadership, with the executive team talking incredibly positively about leadership and the changes they had made for the better. However, others we spoke with did not share this view and were less positive about the direction of leadership, describing challenges and differences of opinion. Staff working 'on the ground' in frontline services did not describe any of these benefits and some told us they didn't feel senior leaders were visible or approachable.

The chief executive had worked in the trust since 2002, holding various posts within the organisation before taking up their current role in October 2017 initially as an interim and then in a substantive capacity. The medical director had held their current role since 2016, having worked in the trust since 1996 and held the deputy chief executive role. The chief operating officer had joined the trust in November 2019. The chief nurse had taken up their current role in 2020 having previously worked in other leadership roles within the trust, and the director of finance had joined the organisation since our last inspection. The Chief Information and Technology Officer was leaving the trust the same week as our inspection, although there was a plan for their replacement.

Both the director of planning and performance and chief people officers were in interim roles. Interim arrangements were in place to provide maternity leadership. The guardian of safer working had largely been absent from their role over the past 12 months, and interim arrangements for cover did not provide the same level of impartiality. An interim chief pharmacist was in post.

The chairman was in a joint role held with South Tees NHS Foundation Trust, and had held this role since September 2021, having previously held a post as a professor at Imperial College London. In February 2022 four non-executive directors of the trust resigned with immediate effect. The trust had a total of three non-executive directors in interim roles at the time of our visit.

Our findings

We spoke to members of the executive and non-executive teams about the resignation of the former non-executive directors. There was a marked difference in the views and approach, with some describing their loss as devastating and leading to instability, a loss of knowledge and a sad time for the trust, while others talked about those who had left being too entrenched within and protective of the organisation, inflexible, and that there was now a good opportunity for change.

We asked executive and non-executives if they felt the board was functioning as a unitary board. Again, we received differing responses, with several stating this was the case, and others acknowledging that realistically, given the amount of significant change the board had gone through and continued to go through, this hadn't been achieved yet. It was clear from our discussions and the resignation of the non-executives, there were significant challenges for the board to work as a unitary board. It was clear from meeting minutes and the trusts own documents that not everyone was 'on the same page'. There was an independent review of the board leadership by NHS England with the outcomes and findings of this was not yet published.

The trust had a plan of board seminars, however, there had not been any significant board 'time out' or planning sessions since a two-day development workshop facilitated externally in 2019. Since then, any board development had been covered as part of business as usual through regular seminars, except for a joint board to board away day with South Tees NHS Foundation Trust in May 2022. The chair and chief executive acknowledged there was more still to do as the two organisations worked towards closer working relationships.

The executive leadership team had recently produced a new leadership 'strategy on a page' which went to the people committee in March 2022, with the plan to co-design a leadership strategy over the coming nine months, underpinned by the trust's '100 leaders' work. The aspiration was to have a leadership strategy in place by December 2022.

Operationally, the trust delivered clinical services through three care groups; Responsive Care, Healthy Lives and Collaborative Care. Each care group had a triumvirate management structure consisting of a clinical lead, a care group manager, and a head of nursing. However, each had different meeting and governance structures, and it was unclear from the information provided how these fed into corporate governance and board structures. Care group one, Healthy Lives, was the biggest, and we were told that there were discussions about the size of this group and whether this needed further subdivision.

BME representation at board level was underrepresented at 5.6%, compared to a BME workforce of 11%. The trust told us they were looking at this when considering longer term recruitment to the board and acknowledged that there was more work to do around attracting those with a disability or other protected characteristic. There had previously been an associate role open to those from a BME background who aspired to hold board positions but needed to develop their skills, but this was currently not in place. However, the trust did have an identified non-executive director with oversight of equality, diversity and inclusion.

During our inspection we found that local leadership at core service level varied. For example, leadership in the children and young people's core service was positive, with new leaders making steps to improve and work on tensions within the department. However, in maternity, the service lacked senior midwifery leadership, with no head of or director of midwifery, and staff expressing concerns around leadership. Processes were in place to ensure that day to day oversight of pharmacy work was managed effectively, however due to a lack of high-level leadership the trusts strategic direction with medicines optimisation had stalled.

We found that the Fit and Proper Person Procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation.

Our findings

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed four executive and non-executive director files in total. Our review included checks for the newest executive and non-executive appointments. All files included references and signatures saying copies of original documents such as degree certificates had been seen.

We also looked at the trust's Fit and Proper Person Procedure and spoke to the company secretary who was responsible for oversight and compliance with the FPPR procedure.

We reviewed the six-monthly self-declarations, made by the directors, to confirm that they remained fit and proper and saw that these were consistently completed.

Vision and Strategy

The service had a vision for what it wanted to achieve, and the trust's vision and strategy were focused on sustainability of services. However, progress on vision and strategy work had been delayed due to the pandemic and some strategies were in draft and not complete.

At our last inspection, we found that there was a clear statement of vision and values, developed collaboratively. We found that strategies were aligned to local plans in the wider health and social care economy.

However, at this inspection we found there were several overlapping strategies, some of which were out of date and had not yet been reviewed or updated. While there were plans for streamlining and putting in an overarching clinical services strategy, this was under review, and it was unclear how these strategies would complement each other, and whether their effectiveness would be monitored in isolation or as linked documents.

The trust's vision was to "provide the best healthcare for everyone within our population." This was displayed around trust buildings. At core service level for children and young people, the care group had a shared strategic vision, which was underpinned by the aim to provide responsive, collaborative care. However, in maternity, we saw no specific vision or strategy, although information provided by the trust reiterated national priorities, and we saw no evidence that staff were engaged with the vision of the care group.

The trust's values were displayed around its hospitals and were in line with the content of the trust's Corporate Strategy for 2020-2025. However, these were not the same values included in the draft clinical services strategy.

From our interviews with executives, non-executives and senior managers they could articulate what the priorities for the organisation were.

The healthy lives business plan incorporated the development of pharmacy services. Five of the 12 priority areas from the plan related to pharmacy and Quality Control related services, three out of five were deemed high priority with expected dates of delivery within the current and next financial year. The trusts medicines optimisation strategy had been developed to incorporate pre-existing strategies and bring the umbrella of medicines into one strategy.

Our findings

The trust's people strategy 2020-2023, described as an overarching strategy, set out the organisation's ambitions to attract, develop, and retain the workforce. This was monitored monthly by the People Committee and minutes of these meetings were shared with the Board each month.

The trust's people strategy 2020-2023, described as an overarching strategy, set out the organisation's ambitions to attract, develop, and retain the workforce. However, there was not yet an organisational development plan underpinning this, and while this would be monitored monthly by the people committee, information would only be shared at board level annually.

A draft clinical services strategy supplied to CQC was not yet completed, with empty sections. An update had been provided to the trust's transformation committee in April 2022. A date for completion of September 2022 had been set. The document did not detail how it would contribute towards the trust's equality duties or tackle health inequalities.

There was no overarching trust transformation plan in place.

A draft quality and safety strategy including a plan on a page had been produced, but not yet approved. The previous quality improvement strategy ran from 2018-2021.The strategy provided a set of measures by which the team would know if they were reaching their aims, however targets set were not specific and it was unclear how they would be measured.

The trust did not have a current engagement strategy, however there were plans to develop one.

The trust did not have a strategy in place for meeting the needs and improving outcomes for patients living with a mental health condition or diagnosis.

The organisation worked within and with the local integrated care system (ICS), but had just begun to think about how its current and proposed strategies aligned with the wider ICS strategy, and there was evidence of this in the draft overarching clinical services strategy.

There was a recognition by some, but not all, senior staff that there were potentially too many strategies, and that others had not been fit for purpose, and that there was further work to do to streamline these.

Culture

Most, but not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Senior leaders were confident there was a positive, open and transparent culture, however, this was not replicated throughout all core services.

At our previous inspection, we found that staff felt supported, respected and valued by senior leaders, and that morale was generally high. At this visit, while we noted that most staff remained positive about and proud to work in the organisation however, some leaders and staff working in core services spoke about a challenging culture in some areas. The trust had experienced departures of some well-known staff, had been ruled against in two recent employment tribunals with some media interest in these. Leaders spoke about the challenges these had posed, the toll that they had taken on staff, and a wish to 'move on' with culture work

During our well-led interviews, we found there was a mixed culture within the board which impacted on relationships between board members; and whilst this was recognised by some members there was more work to do to improve this.

Our findings

The 2021 trust staff survey showed a completion rate 11% higher than the national average. Most results compared very closely, or slightly favourably to, the national average. However, there was a statistically significant drop in the themes of staff engagement (dropping from a score of 7.1 to 6.9) and morale (dropping from a score of 6.3 to 5.9).

Both core services we inspected sat within the Healthy Lives care group. This group scored similarly to the trust survey in all respects, however there were some distinct differences in some staff groups. For example, under the 'raising concerns' questions 'I would feel secure raising concerns about unsafe clinical practice' and 'I am confident that my organisation would address my concern', only 45% of the ante/postnatal unit responded positively, as did 51% of obstetrics and gynaecology, and 55% of community midwifery (against a trust average of 68%.)

Senior leaders talked about having worked hard to improve culture, particularly in midwifery services, and less recently, children and young people's services. They felt that these issues had been largely overcome, however, staff we spoke to during the core services inspection still had concerns about their future direction and leadership and the impact this would have on culture.

Staff we spoke to said that they did feel able to speak up and raise concerns, and in midwifery, staff told us they had seen the Freedom to Speak Up Guardian (FTSUG) in their department. The FTSUG reported to the board yearly through an annual report and prepared a monthly report for the executive team. The FTSUG was appointed in August 2021, with an increase in hours to a full time role.

There were also 10 freedom to speak up champions across the trust and NTH Solutions. All could be contacted by email, and the FTSUG could also be contacted by telephone, however the trust's speak up policy, associated flowchart and poster were confusing and did not clearly state that a member of staff with patient safety concerns could directly contact the FTSUG.

The FTSUG formed part of the formal induction process for new starters and had also attended some volunteer induction sessions. In 2021, the FTSUG had received no cases in quarter one, two in quarter two, 34 in quarter three, and 14 in quarter four. The main themes were around senior management and culture, staffing, patient safety and the working environment. No more detail was presented to board on these themes or any action taken as a result and there was no documentation of any discussion around the sudden increase in Q3.

The trust's guardian for safe working (GFSW) team comprised of the guardian themselves, supported by an administrator. The aim was to support junior doctors in their role and ensure they were represented, and any concerns heard. Unfortunately, both the GFSW and their administrator were on long term leave and had not been in post for months. There was no succession planning, and no-one in a clinical role, independent of the care groups, had been brought in to fill the role. The GFSW reports to board were being compiled by a member of business support, supported by a care group lead. In the absence of the GFSW team there was no oversight of emerging themes coming out of exception reports and therefore no opportunity to address these. We raised this with the medical director who acknowledged the gap but felt this was being managed within the care groups. However, we were not assured there were robust enough arrangements in place to monitor that working conditions for junior doctors were safe or that junior doctors had an independent route to raise concerns.

The trust had five staff networks as follows; Ability (since 2020), Age (older) (since 2021), BAME (since 2019), LGBTQ (since 2020) and Women's (since 2021). There were emerging Age (younger) and Men's networks with chairs yet to be appointed. Staff told us the networks were relatively new and just becoming embedded. The trust's staff newsletter featured regular updates from the networks.

Our findings

The trust commissioned an external cultural and inclusion report, dated January 2022. This found that there was further board development to be done around equality, diversity and inclusion (EDI), noting that although leaders accepted responsibility for EDI, the focus was mainly on compliance, and more visibility and accountability was needed. The report found that the trust did not have a clear EDI strategy or vision, and the organisation needed to strengthen its engagement through a dedicated EDI engagement strategy.

The trust had identified a dedicated non-executive director for EDI.

The workforce Race Equality Standard (WRES) became mandatory for all NHS trusts in 2015 and trusts are required to show progress against nine workforce indicators.

Key findings in 2021 included BME representation remaining broadly representative of BME communities in the North East, but underrepresented at senior management levels, including board, which had representation of 5.6% against a workforce of 11%.

Shortlisted BME applicants were less likely to be appointed following shortlisting than white applicants. This was a reversal of previous years' data and was identified as a priority for improvement.

BME staff were more likely to experience discrimination at work (14.6% compared to 4.3% of white colleagues) and this figure had increased from 11.7% in 2020.

A WRES action plan was produced in response to the above metrics in August 2021 with progress to be reported through annual reports and accounts. The action plan did not show any evidence of monitoring or oversight at board or executive level. There were no set deadlines for any measurable improvement against the action plan and there was no evidence that the action plan had been co-produced with the BAME staff network.

Workforce Disability Equality Standard Data (WDES) was mainly positive, with only one of nine metrics falling slightly below the national average. While employees with a long term condition or disability reported they were less likely to experience bullying or harassment from their colleagues or managers, they would then be less likely than average to report this, had it occurred.

Governance

There were complex arrangements for governance and these did not always operate effectively. The trust had a devolved leadership model and we were not assured the board had sufficient oversight and focus on the operational risks within the trust.

Not all staff in leadership roles were clear about their roles and accountabilities.

At our last inspection we noted that governance structures were clearly set out, effective and understood, and that the board had sought to further strengthen processes. However, at this inspection we noted that the number of subcommittees reporting directly to board was substantial, and key figures told us they spent too much time supporting these meetings and processes rather than focussing on the 'day job'. There was a recognition by some that governance processes were not fully effective, and a further external review of governance systems and processes was planned for this year. The link between governance at care group level and board was not always effective.

Our findings

There were 10 committees that reported directly into board. These were; Remuneration, Audit, People, Finance, Transformation, Charitable Funds, Planning Performance and Compliance, Investment, Digital Strategy and Patient Safety and Quality Standards. As many of these committees required non-executive attendance to ensure quoracy, the departure of many non-executive board members had meant an over-utilisation of the remaining non-executive members, who, alongside others, expressed concern at the amount of committees they had been asked to take part in.

The board did not receive full reports from these committees, nor were updates by exception captured in board papers. We were therefore not assured that there was a 'ward to board' thread running through the organisation's governance systems. We were told that the board performance report had not met NHS guidelines until May 2022.

A draft quality and shared governance strategy dated 2022-2025 was also shared with CQC. This detailed the way in which the three care groups; Healthy Lives, Responsive Care and Collaborative Care shared information with board, which was through the trust's patient safety and quality standards committee (Ps&Qs). All three care groups held regular patient safety meetings. However, there was no standard agenda across the groups, and we saw from minutes that different items were discussed, for example, one care group discussed quality improvement, but not emerging risks, another discussed risks but there was no mention of quality improvement, and the third had an entirely different agenda, discussing neither. Governance and safety leads within the care groups met with corporate governance staff regularly and shared information, however they explained that the care groups essentially managed themselves, and there were few governance threads from one care group to the next, and from the care groups into the wider structure.

Care group patient safety meeting minutes were not discussed at Ps&Qs or attached to the minutes or agenda. Therefore issues shared at care group level would not routinely be considered for discussion either at Ps&Qs or subsequently at board. There was also no standing agenda item on the agenda for either Ps&Qs, nor care group patient safety for items for escalation. We were not assured that the current system enabled the flow of information from 'ward to board', nor that board members would have any routine oversight of the work of the care groups.

Ps&Qs covered the elements expected of a trust quality and safety committee, such as incidents, claims, concerns and complaints and risk. However, on one occasion in the previous six months the meeting had not been quorate by the end of the meeting (due to a Director having to leave the meeting urgently) which led to an inability to ratify a policy on this occasion. This policy was subsequently approved.

Systems were in place to support governance arrangements however the interim chief pharmacist told us they did not sit on key meetings due to time and capacity pressures.

Board papers were not kept up to date and published in a timely manner. Two weeks prior to our visit, no board papers from the current year were visible on the trust's external website, although this was rectified during the inspection.

We reviewed the trust's policies, guidelines and procedures. A total of 34 of 269 guidelines displayed on the trust's intranet were out of date. These included anaphylaxis for adults, home births, and a guideline for the management and investigation of medication incidents. The trust's care after death policy, learning from deaths policy, and appraisal policy were also out of date.

Serious Incident review process

We reviewed six incident files and found that while these were generally well completed, although they lacked key information. For example, none of the files captured a patient's date of birth, and only two of the six showed evidence that patients and their families had been consulted and feedback sought around the incident investigation process.

Our findings

Only one of the six showed evidence that Duty of Candour (a legal requirement for trusts to say sorry when things have gone wrong) had been discussed with the patient or their family and there were no copies of Duty of Candour letters to patients or their families in the incident folders provided. At core service level, we saw evidence that Duty of Candour had not always been applied in line with regulations.

Learning from incidents had been identified in all the six incident files we looked at. However, in two cases, actions for follow up had not been completed.

Complaints

We reviewed five complaints files supplied by the trust. The complaints files contained limited evidence that complaints had been risk assessed to consider any ongoing clinical risk. Although the front sheets of most, but not all complaints files had a tick box for the consideration of Duty of Candour, these were not always filled in, and within the complaints files themselves there was no evidence of Duty of Candour requirements having been fulfilled when this applied. Most complaints processes were closed within the stated time, but not all. The trust's most recent annual complaints report showed that 96% of complaints were closed within an agreed timescale. The trust's complaints policy stated that letters to complainants would be signed by either the Chief Executive, or a nominated deputy. Letters to complainants were signed by a mixture of executive and non-executive respondents. We saw acknowledgement letters to patients stating they would receive a response from a member of the executive team, however this was not always the case. It was not clear from complaints files what learning and improvement had been made. For example, one letter to a patient stated that to avoid recurrence the trust would remind staff of their attitude and remind staff to check medication. As both are standards the trust would expect of its staff anyway, these were not actions and did not give assurance that any improvements would be measurable and how they would assess improvements had been made. One file contained a note asking a member of staff to chase up evidence of service improvements almost three years since the original complaint was received. We were therefore not assured that the complaints process was robust, worked well to support patients, or led to change through learning.

The trust did not undertake regular audits around Duty of Candour. The trustwide patient safety panel reviewed those incidents where Duty of Candour had been identified as applicable, however, we were not assured that the trust had full oversight of its efficacy in meeting its statutory duty.

Management of risk, issues and performance

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

At our last inspection, we found that the trust had improved its processes to manage risk and embed this across the organisation. We found that this had generally been sustained at this inspection, and that the trust was using a variety of methods to ensure that risk was escalated.

The trust managed risk in a number of ways. Firstly, a safety panel met every week. All serious incidents, incidents meeting the Duty of Candour threshold and complaints themes (but not individual complaints) were reviewed. The trust's safety planning meeting met separately weekly, following which those incidents that appeared significant were reviewed by the medical director and chief nurse.

Our findings

While the safety meetings were attended by the safeguarding and members of clinical teams, legal and patient complaints teams did not feed into these meetings. Assurance around clinical safety and quality was very data driven, and it was unclear what further triangulation processes were in place to support this.

We heard that an emerging risk over the previous 12 months had been around cultural issues in maternity. We were told by four different versions of how the issues had been identified; the chief executive personally discovered the risk, the FTSU discovered the risk, the risk became apparent firstly through the data, and that the risk was discovered by a NED and the chief nurse when speaking to staff. It was therefore unclear as to how and when this risk was initially identified and what learning had been put in place as a result. However, the lack of professional leadership in maternity services was captured on the board assurance framework (BAF) as part of a wider risk around incidents leading to loss of public / stakeholder confidence and increased scrutiny.

The trust had engaged external bodies in several external reviews over the past 18 months and continued to use external validation as a way of checking its own systems. Trust internal audits had been significantly impacted by the pandemic, and plans for 2021-2022 were being rolled over in all care groups with plans for delivery in the current year.

The trust's risk management strategy was in date; however, the trust's risk appetite statement and key milestones only covered the period 2020-2021.

The trust's (BAF) was the mechanism by which the board gained assurance against its responsibilities. This was reviewed quarterly by the board. We saw from board papers that the BAF was discussed regularly, and risks were kept up to date. The highest rated risks related to the wider integrated care partnership and the impact this may have on the trust, and financial risks. Innovative ways of representing the BAF in pictorial format were being trialled as a way of enabling clearer 'at a glance' views of overall risk. Performance dashboards were also used at board level, and care group level to support the identification of risk.

Leaders were relatively consistent when describing their top three risks which were the trust's estate (buildings), workforce and finances.

The trust's operational risk register was up to date and we could see that this was regularly reviewed. Risks that had been on the register a long time had been identified as such and clear reasons given as to why, for example, a risk that had been on the register for over two years had been recognised as a tolerated risk as all controls were in place within the trust pending a shift in local and national guidelines. However, two risks had not been reviewed since 2020, and a risk added in 2021 had not been reviewed since it was added, even though the mitigation was to fill a non-specialist post. This was one of two moderate risks on the register (there were six risks rated as high).

The trust's average medicines reconciliation figures were 65.6%, which fell below the national average and below the trust's targets. A service improvement plan was in place to support the improvement of this figure. The medicines risk register held several key risks which were reviewed; however, progress was limited due to the interim nature of top-level leadership. Medicines incidents were reviewed by the trust medicines safety officer who worked locally and participated in regional and national groups to share and learn from medicines safety.

Information Management

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

Our findings

At our last inspection, we saw that systems for the collection and analysis of data were appropriate and usually accurate, and that information technology systems were used effectively. During this visit, we noted that this trajectory had been maintained, with the trust investing strongly in electronic systems as part of its status as an accredited national digital leader.

The trust's digital strategy focussed in infrastructure, integration and interoperability. This was aligned to the ICP's direction of travel. Three years ago, the trust had implemented a digital records system which had enabled information on a wide array of patient metrics to be captured and analysed in more detail than previously. The system could be filtered from trust wide performance metrics, right down to a single ward. There were plans in place for wards to receive electronic touchscreens to make it easier for staff to interrogate the data themselves in real time subject to the correct access and training, however, this was still at the pilot phase.

The trust's information governance strategy was in date and monitored by the information management and information governance group, and digital strategy committee, which reported directly to the transformation committee.

The most recent data security and protection toolkit was completed in 2021, and assurance had been gained at 'substantial' level with all standards met. Data protection toolkit training was 97% completed.

A business case was going to board for a dedicated cyber security expert within the IT team, and the trust was aiming for accreditation under Cyber Essentials Plus and the ISO/TR 13028:2010 digitised records standard as part of their electronic document management services

Electronic prescribing systems had been partially rolled out across the trust but were not yet available in all areas. This featured on the trust's risk registers; and oversight of these risks was under review at appropriate governance meetings.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They acknowledged there was more to do around wider engagement with equality groups, the public and local organisations. They collaborated with partner organisations to help improve services for patients.

At our last inspection we found that the trust had a range of mechanisms to proactively capture people's views and had continued to review and improve these mechanisms. During this inspection we found that due to the COVID-19 pandemic, it had been challenging for the trust to maintain all its usual engagement avenues, but that plans were in place to pick these up again as soon as capacity allowed.

The trust did not have a current staff engagement strategy. Work had started in November 2021 and was continuing to develop one, but there was no draft available at the time of our inspection.

There was no current patient experience strategy, but work was underway as part of improving together work. The strategy was being developed with staff and partners, but patients had not been consulted.

Prior to the pandemic, local Healthwatch visits had provided important feedback around areas such as discharge. Links with local Healthwatch had been maintained, however, due to the pandemic, these visits had not yet resumed.

Our findings

Leaders told us that they hadn't really had a chance to engage with the wider local community and did not offer any timescales for doing so.

The trust's patient experience and complaints meeting had recently moved back to meeting face to face, having taken place on videocalls during the pandemic. We heard that attendance could sometimes be a challenge, but that the terms of reference had been recently refreshed to revitalise the meeting and make it more meaningful.

Friends and Family tests were regularly collated and discussed at governance meetings. Leaders could access live data through the trust's electronic dashboard system. We heard that all feedback was valued by leaders, and that the chief executive took a keen interest.

A patient story was presented at every board meeting. We heard these were very well received and helped the board to remain patient centred.

The trust was fully engaged in its local integrated care partnership with the chief executive taking a lead on equalities. Leaders talked positively about working relationships with the wider system and closer working with their nearest neighbouring trust.

Staff in the core services we visited had varying views of leaders' visibility, with some saying that they did see leaders, and others not at all. Non-executive leads told us that they regularly visited clinical areas where appropriate, and one had worked a shift as a porter to gain experience from a new perspective.

Learning, continuous improvement and innovation

Staff were committed to learning and improving services. They had an understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

At our last visit, we found that there was a strong focus on continuous learning and improvement. During this inspection, we found that there remained a drive to improve.

Since April 2017, the national 'learning rom deaths' framework had stipulated that trusts must collect and publish, via quarterly public board papers, information related to deaths of patients.

The trust had a medical examiners team of eight people, trained in independent scrutiny of non-coronial death in the trust, overseen by the medical director who was the executive lead for mortality.

We interviewed the medical director and lead medical examiner, and reviewed four cases subject to a review after patients had died. We found that these were well constructed, and that communication with patients' families and carers had been timely and compassionate. One of the four reviews identified potential learning, but it was not clear from the file how this had been communicated more widely. The processes and practices used were adherent to national guidance issued in 2017, however, the trust's own learning from deaths policy was out of date and had not been reviewed since 2021.

The trust had created a faculty of leadership and improvement in 2021 to support improvement across the organization. This body had oversight of all quality improvement across the organization. However, this was in the early stages, with

the first 16 staff completing their practitioner programme in May 2022. Quality improvement leads were also based within the care groups, with four quality improvement leads completing a PgCert in patient safety and quality improvement. The trust offers a basic e-learning module on quality improvement, which has been completed by 1692 staff since its launch in 2020.

During the early stages of the COVID-19 pandemic, it was recognized that there was a need to reconfigure the trust's respiratory provision, as currently only 19% of beds were in side rooms due to the age of the trust's hospital buildings. The new respiratory unit was designed and delivered to meet these needs in challenging times. However, we found on inspection that the unit did not meet NHS guidance for the provision of single sex washing and toilet facilities. We were told this was because patients were not mobile so there was no need to have single sex facilities however when we visited the ward again, we observed a patient walking to the toilet. We shared this with the trust at the time of the inspection.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good ➔➔ Sep 2022	Good ➔➔ Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good → ← Sep 2022	Good → ← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
One Life Centre	Good Feb 2016	Good Feb 2016	Not rated	Good Feb 2016	Good Feb 2016	Good Feb 2016
University Hospital of Hartlepool	Good → ← Sep 2022	Requires Improvement ↓ Sep 2022	Good → ← Sep 2022	Good → ← Sep 2022	Requires Improvement → ← Sep 2022	Requires Improvement ↓ Sep 2022
University Hospital of North Tees	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good → ← Sep 2022	Good → ← Sep 2022	Requires Improvement → ← Sep 2022	Requires Improvement ↓ Sep 2022
Overall trust	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good → ← Sep 2022	Good → ← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for One Life Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Feb 2016	Good Feb 2016	Not rated	Good Feb 2016	Good Feb 2016	Good Feb 2016

Rating for University Hospital of Hartlepool

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children & young people	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016
Outpatients and diagnostic imaging	Good Feb 2016	Not rated	Good Feb 2016	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016
Surgery	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Maternity	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022
Overall	Good →← Sep 2022	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022

Rating for University Hospital of North Tees

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Services for children and young people	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Good ↑ Sep 2022	Good →← Sep 2022
Critical care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Outpatients and diagnostic imaging	Good Feb 2016	Not rated	Good Feb 2016	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016
Surgery	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Urgent and emergency services	Good Mar 2018	Requires improvement Mar 2018	Outstanding Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Maternity	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022
Overall	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Community health services for adults	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016
Community health services for children and young people	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Community end of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Overall	Good	Good	Good	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

University Hospital of North Tees

Hardwick Road
Stockton On Tees
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www.nth.nhs.uk

Description of this hospital

University Hospital of North Tees provides acute care services for North Tees and Hartlepool NHS Foundation Trust.

The trust provides integrated hospital and community-based services to approximately 400,000 people living in East Durham, Hartlepool, Stockton on Tees and surrounding areas including Sedgefield, Easington and Peterlee. It has a workforce of approximately 5500 staff.

The trust provides the following acute core services:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostics

Maternity

Requires Improvement ↓

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.

Nursing and midwifery staff received and kept up to date with their mandatory training. The trust had a target compliance of 90%, at the end of March 2022 95% of midwives and 90% of clinical support staff had completed their mandatory training.

Medical staff received and mandatory training, however at the end of March 2022 only 80% of staff had completed their annual training.

The mandatory training was comprehensive and met the needs of women and staff. The service had an education lead that monitored mandatory training, adapting sessions yearly based on incidents within the service.

The training lead and managers monitored mandatory training and alerted staff when they needed to update their training. Staff reported they were given protected time to complete their training.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. All medical and midwifery staff received level three children's safeguarding training. Compliance rates were 92% for medical staff and 99% for qualified staff against a target of 100%. 100% of medical and qualified staff had completed level 2 safeguarding children.

100% of medical and qualified staff had completed adults safeguarding level 3 and 98% of medical and 94% of qualified staff had received level 2 safeguarding adults training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them, however we did not observe safeguarding information being shared during handovers between midwifery or medical staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to contact the lead midwife for safeguarding who provided support and supervision for staff.

Maternity

The service had a baby abduction policy; we saw ward areas were secure, and doors were monitored. Due to the COVID-19 pandemic, the trust had not undertaken a simulation of a child abduction in the reporting period, however we saw this had been reported at board level, and there were plans in place to recommence scheduled simulations.

Cleanliness, infection control and hygiene

The service controlled infection risk. 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 clean and well-maintained.

Hand hygiene audits for the previous year demonstrated 100% compliance in all but two months across the four maternity areas. Peripheral cannulation audit data showed 100% compliance for the delivery suite and between 75% and 90% compliance for ward 22.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff in ward environments followed infection control principles including the use of personal protective equipment (PPE), however we observed staff not adhering to infection prevention control (IPC) measures within theatre with PPE not being worn appropriately in one case and safe IPC practice not being followed in another.

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

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

The unit had 11 labour rooms, two obstetric theatres, two bereavement suites, a single occupancy high dependency room and areas for high risk women. A two bedded induction suite and recovery room along with a birthing pool room were also available.

The antenatal and postnatal ward (ward 22) as well the neonatal unit were located on the floor above the delivery suite, staff had priority access to lifts. Ward 22 had a four bedded transitional care bay.

Women could reach call bells and staff responded quickly when called. Results from the 2022 CQC maternity survey showed the service performed the same as other trusts for staff being able to access a member of staff when needed.

The service had enough suitable equipment to help them safely care for women and babies and staff carried out daily safety checks of specialist equipment. Adult resuscitation trolleys were surface checked daily, baby resuscitation equipment was available for babies in both the delivery suite and on the postnatal ward. Obstetric emergency trolleys had been appropriately checked, were stocked, and equipment was in date and ready for use.

Equipment servicing and electronic safety checks were monitored by the trust's estates team. Records we reviewed showed no equipment was past its planned preventative maintenance review.

The pool room was equipped to get mother and baby out of the pool in an emergency however the room did not contain a bed. Staff we spoke to said a trolley would be brought to the room if needed and rooms were available close by to transfer into.

There was no equipment in place to monitor and alert staff if someone tried to remove a child from the service, but doors into and out of maternity areas were secure and monitored electronically.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff used recognised to tools to monitor women and babies however compliance to these tools was not monitored. Not all areas of practice followed best national guidance.

Staff used a nationally recognised tool to identify women and babies at risk of deterioration. Women were monitored using the modified obstetric early warning system (MEOWS) and staff told us there was process in place for escalation. We observed evidence MEOWS had been completed accurately in women. Midwife staff were trained to take blood cultures preventing delays in starting treatment if a woman became unwell with sepsis. MEOWS audits for the period April 21 – April 22 showed overall compliance ranged from 80% to 99%, with five months above 95%. Action plans were in a place to address and improve compliance.

Babies were monitored using the Paediatric Early Warning Score, audits against compliance with the tool were undertaken monthly however from the information provided it was not clear which areas the audit had been carried out.

We saw evidence of fetal monitoring during labour and a buddy system ('fresh eyes') was in place to review cardiotocograph (CTG) traces during continuous fetal monitoring. However, practice we observed did not follow the requirements for an hourly approach to fresh eyes and this wasn't reflected in policies, we did not see any evidence the service was updating its practice in line with requirements for frequency of monitoring, however the service did have a fetal monitoring lead and regular multidisciplinary CTG training was undertaken.

Staff completed risk assessments for each woman on admission / arrival and actioned any specific risk. Staff we spoke to said medical staff were generally responsive when called and consultants were available during difficult births however there could be delays in medical staff review for patients in the ANDU.

The service had completed an audit of the World Health Organisation maternity theatre checklist, in March 22, it was not clear from the information provided if all areas of the checklist had been audited against or how frequently the audit was completed. We did see evidence the checklist had been completed in notes reviewed. Swab count audits showed compliance between 85 and 100% for the period September 2021 to February 2022.

The ANDU had systems in place which allowed electronic interpretation of fetal heart rate monitoring to be undertaken which could potentially improve outcomes.

Staff did not always share key information to keep women safe when handing over their care to others. Multidisciplinary and team handovers were not carried out using the recognised situation, background, assessment, recommendation (SBAR) technique and we were not certain this was routinely carried out during one to one midwife handovers. Recording of SBAR handovers was limited.

The service had access to mental health support twenty-four hours a day and we were told the specialist support teams were responsive when called.

Maternity

Midwife staffing

The service had 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. However, the service had a rising vacancy rate and did not monitor key safe staffing metrics.

The service had enough nursing and midwifery staff on the days of our visit to keep woman and babies safe, however the service had 13 whole time equivalent (WTE) midwife vacancies in May 2022 and vacancy rates were increasing. A nationally recognised assessment of the workforce was last completed in 2019 and the trust were planning to commence the required three yearly establishment review, in line with national requirements.

Staff we spoke to told us they felt staffing levels were generally safe however they often struggled to take allocated breaks. We saw escalation of staff from the labour ward to delivery suite to cover a busy period.

The service had a dedicated team that cared for women who were booked for a planned caesarean section. We were told one midwife would complete all planned sections for the day and on the day of inspection only two out of a planned four midwives where on shift. We were not assured the day to day workload of this team was safe.

One to one care in labour and a dedicated labour ward coordinator are recognised staffing measures to help improve outcomes for women and babies. One to one care of women in labour, for the period February 21 to March 22, ranged from 78 to 92%. The service did not monitor how often the labour ward coordinator was not supernumerary, however staff told us this was uncommon

The service used an acuity tool on ward 22 and the delivery suite with data entered six times a day. The tool used real time assessments of staffing levels in relation to the women's care needs and monitored red flag data.

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing and is recommended by the National Institute of Health and Care Excellence (NICE).

We were not assured the service was utilising the outcome from the acuity tool effectively, no red flag reports were available and staff in some areas reported being unsure if the data they were entering was correct. There was no sharing of acuity data between the delivery suite and ward 22. Staffing incidents were reported using the trust's incident reporting system.

Managers had not recently used agency staff and utilised their own staff for bank shifts. The service used between three and eight WTE midwifery bank staff for the period March 21 to April 22.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. The service had ten consultants with one vacancy at the time of the inspection. Consultants provided a minimum of 98 hours of cover each week which met the Royal College of Obstetricians and Gynaecologists requirements for the number of births.

Consultants were available on site between 08.00 and 22.00, 7 days a week and on-call outside of these hours. Guidance had been introduced on when consultants needed to attend for emergencies which was reported to be working well. Staff reported consultants were responsive when contacted on delivery suite and ward 22. There could be delays in medical review on the ANDU.

The service had 24-hour anaesthetist cover with two anaesthetists available. Women could receive epidurals 24 hours a day.

Ward rounds occurred twice a day and day and staff reported consultant presence at all morning and most evening rounds.

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.

Women's notes were comprehensive, and all staff could access them. The service used a combination of electronic and paper records. We observed gaps in the documentation of women's SBAR handovers.

The service used proformas for staff who were transcribing records of care during complications of pregnancy and these were audited to ensure compliance.

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

The sharing of information on discharge was managed by the ward clerks who would send electronic referrals to GP and community midwifery teams.

Records were stored securely.

The service kept records of referrals to specialist centres, an audit undertaken for the period January -March 2022 highlighted 100% of records reviewed had evidence of the referrals made.

Medicines

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

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

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

The service was supported by a pharmacist who visited ward 22 daily.

A number of midwifery staff worked to patient group directions (PGD's). All midwifery PGD's were managed by a unit manager who had a system in place to ensure annual compliance. New PGD's were not implemented until training compliance reached 80%.

Staff completed medicines records accurately and kept them up-to-date.

Maternity

Staff stored and managed all medicines and prescribing documents safely.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents however learning from incidents was not widely shared.

Staff knew what incidents to report and how to report them, however we were not assured incidents were appropriately graded due to the high nature of those categorised as low or no harm compared to incidents of moderate harm of above. For the period April 21 to March 22, 99% of all incidents were categorised as low or no harm. From the data we reviewed we identified incidents of post partum haemorrhages of over 1500mls categorised as no harm as well as incidents of women being transferred to intensive care classed as low or no harm.

The service held weekly MDT risk management meetings where any incidents that were to be closed were discussed. Staff told us most incidents were investigated at ward level. We reviewed minutes from these meetings and found that learning was not always identified, despite incidents being discussed.

We saw limited evidence that learning from incidents was shared routinely amongst all staff, although we did see sharing of learning undertaken within the ANDU. Information displayed in other areas was old or not dated and daily huddles did not routinely include shared learning. Staff were unable to recall any recent incidents and associated learning.

There were zero never events within obstetrics in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Managers reported relevant incidents to external organisations for investigation. Between May 2021 and August 2022, three incidents had been referred for external investigation to the Health and Safety Investigation Branch (HSIB) and one incident met the threshold for NHS serious incident reporting (including those also referred externally). HSIB conducts independent investigations of patient safety concerns in NHS-funded care across England.

Perinatal deaths within the service were investigated using the Perinatal Mortality Review Tool (PMRT). The PRMT is a national programme aiming to standardise perinatal mortality reviews across NHS maternity services.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance, however some areas of practice had not been updated and evidence based practice was not always followed.

Maternity

The service had an annual audit programme in place and took part in national and local audits. Local policies, procedures and clinical guidance were accessible on the trust intranet site. All maternity service policies and procedures we reviewed during our inspection were found to be up to date. However, we found the practice and policy for electronic monitoring of fetal heart rates had not been updated in line with national guidance.

Fetal growth was monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by MBBRACE-UK (2015) and in line with current NICE Guideline (CG62).

The Saving Babies Lives Care bundle, Version 2 (SBLCBv2) is a series of measures introduced by NHS England in 2019 to help reduce perinatal mortality, element 2 requires risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction. The service was utilising the Perinatal Institute Growth Assesment Protocol (GAP) which included customised growth charts to help in meet this requirement.

The service had three midwifery sonographers who community midwives could refer to if concerns were identified with fetal growth restriction.

At handover meetings, staff did not routinely refer to the psychological and emotional needs of women, their relatives and carers. We did not observe the recognised SBAR format for handover being used during handovers of care between staff.

The service undertook screening for gestational diabetes in line with national recommendations.

Delayed (optimal) cord clamping can have positive impacts on the health of the baby. In practice we observed we did not see delayed cord clamping, we did however observe parents involved in the delivery and skin to skin contact following birth.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, they made adjustments for women's religious or cultural needs.

The service had previously achieved full accreditation from the UNICEF baby friendly initiative. Reaccreditation was overdue however the service had started the initial stages of the process and submitted a certificate of intention. The programme accredits units for supporting breast feeding.

The service did not have a specialist breast feeding team and this was on the service's risk register. The wards had fridges for mums to store milk, however these were locked and not freely accessible.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

The service had access to an anaesthetist 24 hours a day, a snapshot audit into the time taken for women to receive an epidural showed no women waited longer than the Royal College of Anaesthetists target of 30 minutes with the average time being 14 minutes.

Women we spoke to did not highlight any concerns with their pain management, they reported they were provided information about their options in relation to pain relief.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

The service monitored the effectiveness of care and treatment, however information on outcomes was not always accessible to all staff.

The service participated in relevant national clinical audits and had an audit programme in place.

Outcomes for women were positive, consistent and met expectations, such as national standards.

In the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) perinatal mortality surveillance report published in October 2021 (based on births in 2019), the stabilised and adjusted perinatal mortality rate at the trust was within 5% of the comparator group average for all births and those excluding congenital anomalies, this meant it was not significantly different to expected. The service had an improvement plan in place based on the outcomes of the report.

Better Births (2016), the report of the National Maternity Review, recommended that a nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services. A national series of clinical Quality Improvement Metrics (CQIMs) and were introduced.

For the period April 2021 to March 2022 the service had lower rates of post partum haemorrhages per 1000 women than the MBRRACE- UK average. For the same period the service had higher rates of 3 and 4th degree tears per 1000 women than the MBRRACE-UK average for eight out of the nine months data was available. Local performance dashboards highlighted emergency caesarean section rates were below trust targets for 10 out of the 12 months.

Local performance dashboards were available that monitored maternity metrics against targets. However, it was not always clear where the targets where obtained from and they did not match those set by the local maternity and neonatal system. Managers across the service weren't aware of how to access the dashboard and we saw no evidence at ward level of improvements to the service based on outcomes.

Transitional care was undertaken on the postnatal ward with a transitional care bay and dedicated transitional care midwife and support worker in place. Support was also provided by specialist paediatric nurses where required. A step-down process was in place for babies which involved a review by a paediatrician or advanced neonatal practitioner. Breastfeeding rates at birth were below the 50% target for eight out of 10 months for the period April 21 to March 22. No data was available for breastfeeding at day 10. The service did not have any specialist infant feeding support for women.

Competent staff

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Newly qualified midwives undertook a preceptorship programme and worked rotationally to develop their skills across all areas of midwifery.

Maternity

The trust had adopted the A-EQUIP (Advocating for Education and Quality Improvement) model of supervision and there were three Professional Midwifery Advocates (PMA) within the service and a further two being trained. Staff reported the PMA's were supportive.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates at the end of March 22 were 91% for midwives, 75% for medical staff and 100% for support staff. The trust had a target of 95% for appraisals.

The service had an education lead who supported staff to complete training relevant to their role. Recent skills and drills training sessions had included newborn resuscitation, pool evacuation, post partum haemorrhage and cord prolapse.

Staff had received training and assessment on fetal heart rate monitoring through a maternity specific training programme (K2). Compliance rates for training were 100% for medical staff and 98% for midwifery staff up to March 2022.

Antenatal and newborn screening updates were completed annually by all staff, compliance rates were on average 91% up to March 2022.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff we spoke with said they had a good working relationship with the MDT. Midwives told us they were happy to raise concerns and challenge practice with medical staff where they felt this would help to keep women and babies safe.

Staff reviewed women's mental health and the service and was supported by the reflection's midwives. The reflections service offered a midwifery led debriefing service to help people talk through their birth experience.

The service had a community based perinatal mental health lead however they had no protected time for the role and did not have a caseload for mental health. The service reported they were well supported by teams from the local mental health trust.

The service worked with neighbouring trusts to support women needing specialist care at a fetal medicine unit. Midwives worked alongside consultant leads, community midwives and specialists at regional centres to provide MDT care and care planning for women.

The service completed routine handovers to the community team via electronic referrals and community teams would contact the service daily for details of recent discharges.

Seven-day services

Key services were available seven days a week to support timely care.

Ward rounds were undertaken twice a day on labour ward, including at the weekend. Women were reviewed by consultants depending on their care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Maternity

The ANDU was accessible for women seven days a week and women could contact triage at any time.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

The service provided guidance and encouragement to women on vaccinations including flu, pertussis and coronavirus and we saw evidence that Vitamin D was appropriately offered to some women. Some midwifes were trained to give vaccinations.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw evidence that carbon monoxide was monitored in women.

Consent, Mental Capacity Act and Liberty Protection Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

All staff received training on the mental capacity act and liberty protection safeguards (formerly deprivation of liberty safeguards) as part of their safeguarding training.

All staff received annual consent training, the trust had a 95% target for compliance, all but one staff group within maternity where meeting this target with 100% of medical staff and 97% of midwives having completed the training.

During the inspection staff we observed written consent being checked for women undergoing elective caesarean sections.

Consent for screening was undertaken and sonographers would request this if not completed.

In the 2021 CQC maternity survey the service did better than expected for questions being asked around women's mental health.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Maternity

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Staff were very attentive to patient needs. Call bells were answered promptly.

We observed good interactions and communication with patients and staff.

Women said staff treated them well and with kindness.

Staff followed policy to keep women's care and treatment confidential.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. However, the service lacked specialist support or training. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. The service had a bereavement suite for women however no specialist bereavement midwife was in place, and staff did not receive any specialist bereavement training.

Staff supported and helped them maintain their privacy and dignity.

The service had two reflections midwives that were available to provide support for people to discuss the events surrounding their birth.

In the 2021 CQC maternity survey the service did better than expected for questions around mental health during pregnancy.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Women we spoke to said staff spend time explaining their care and gave reassurances.

Staff talked with women, families and carers in a way they could understand. The service did better than expected for being spoken to in a way they could understand in the 2021 CQC maternity survey.

The service ensured women had appropriate birth plans in place and encouraged partners to support.

For the period August 2021 to February 2022, the service received positive feedback from their friend and family survey, however this was lower than the trust target of 95%.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Maternity

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service worked with others in the wider system and local organisations to plan care, however there was no active partnership group to develop the service and women who needed specialist care did not have access to dedicated specialist midwives.

Managers planned and organised services so they met the needs of the local population. The service had one continuity of care team and prior to the pandemic there were plans to increase this approach to midwifery care. In line with recent recommendations, plans for further continuity teams had been paused

Facilities and premises were appropriate for the services being delivered. Two theatres were available to enable a dedicated elective and emergency caesarean section theatre. The service had two bereavement suites which were supported by a separate entrance. The rooms had been made to be more sympathetic looking, however some aspects remained quite clinical.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, this was provided by specialist teams from the local mental health trust.

The service did not have an active Maternity Voices Partnership (MVP). The MVP is an NHS working group and includes a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care based on local needs.

The acute service did not have some specialist midwives in post to help care for women in need of additional support or specialist intervention. There were no acute leads in areas such as teenage pregnancy, substance misuse, bereavement or diabetes. We saw that following the inspection, a proposal had been made to strengthen the midwifery service, including to introduce a bereavement and a diabetes specialist midwife; these were two of the areas which had been identified as a gap in the service. We did not see timescales for implementation of the identified midwifery structure, and the structure did not address specialist midwives with lead areas to include teenage pregnancy and substance misuse.

Managers ensured that women who did not attend appointments were contacted. Systems were in place to communicate with a woman and their community teams if they did not attend an appointment.

SBAR handover was not well documented and we saw little evidence this was routinely used during handovers.

Partners were able to visit the delivery suite and ward 22 during the day.

Meeting people's individual needs

Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Managers made sure staff, women, loved ones and carers could get help from interpreters or when needed. We did not see any evidence of information available in other languages than English.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Transitional care was undertaken on the postnatal ward with a transitional care bay and dedicated transitional care midwife and support worker in place. Support was also provided by specialist paediatric nurses where required. A RAG rated admissions and step-down process was in place for babies which included a twice daily review by a paediatrician or advanced neonatal nurse practitioner.

National guidance outlines that women should be provided with three choices of places to birth. The service offered all women the opportunity to birth at home, in hospital with MDT input, and the midwifery led unit, during our inspection we were unable to distinguish how care in the midwifery led areas differed to that of medically led areas. We saw place of birth was documented in records we reviewed.

Separate rooms were available in outpatients and the ANDU for people who had received bad news. Guidance was in place for staff to support in working with bereaved parents and covered taking their baby home, post-mortem, placental samples and histology. Bereavement support officers and chaplains of all faiths were available on site to support families. However, the service lacked specialist bereavement midwives or training.

We saw evidence that women were asked about domestic abuse. In outpatients staff had the opportunity to see women without their partners present to provide occasions for women to raise concerns.

All women were booked into the service were reviewed by two specialist midwives. The clinical specialist midwives worked alongside consultants and triaged each woman into low or high-risk categories. The specialist midwives also reviewed women who fell into certain high-risk categories including those with a raised body mass index, those that smoked, had diabetes or were experiencing multiple pregnancies.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The service had a maternity escalation processes which was integrated into local maternity systems. The process involved two stages with the first being internal escalation. For the period August 2021 to May 2022, the service had triggered the internal escalation policy 29 times. There had been no unit closures during the same period.

Staff we spoke to said it was rare women gave birth outside of the designated labour ward. Occasionally they would be asked to support the emergency department with a birth, however this was also uncommon. There was dedicated access to the labour ward for women attending at night.

The ANDU offered appointments for women with referrals coming from GPs, community midwives and women themselves. The department used a RAG rated triage process for women which was based on risk.

There were three midwife sonographers, two scanned babies from 26 weeks, one had undertaken further training and was able to scan before this. The midwives helped improve flow through the department.

Maternity

All women who rang into the service were triaged by midwives based at Hartlepool Monday – Friday, 9am till 5pm, calls were triaged by North Tees ANDU and the labour ward after this.

The service had 18 clinics cancelled within six weeks of the appointment, for the period November 2021 to April 2022, 14 of these were at North Tees and four at Hartlepool. The service did not monitor outpatient waiting times specific to the service. Process and policies were in place to monitor women who did not attend for an appointment.

For February 2022 19.8% of maternity patients did not attend their appointment against a standard of 13.2%, this was an increase from January 2022.

For the period April 21 to March 22 the service had met local induction targets of less than 46.9% for eight out of the 12 months, there were four delays to inductions reported as incidents for the same period.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them.

Women, relatives and carers knew how to complain or raise concerns. There were posters in clinical areas which gave patients information on what to do if they had concerns about their care, including contact details for the patient experience team.

For the period May 2021 to May 2022 the service received 34 complaints, communication was the most complained about area with six of the 34 complaints. Staff and delays to treatment were also areas of concern with five and three complaints respectively.

For the period May 2021 to May 2022 the service had received 68 compliments about the care and treatment received.

Managers investigated complaints and identified themes.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders in post had the skills and abilities to run the service, however the service lacked senior midwifery leadership and clear structures.

The service was part of the Healthy Lives care group (care group 1). Information provided on leadership structures suggested the care group was led by a director with a clinical lead, head of nursing and care group manager.

Maternity services were led by a clinical director and an obstetric lead supported by a head of women's health and an operational manager.

Ward managers were in place to support teams on the delivery suite, ward 22 and outpatients and ANDU. The service lacked a midwifery leadership structure above the ward managers. A senior midwife (employed on a consultancy basis) had been recruited to support the service following changes in senior midwifery leadership. They had been in post two weeks at the time of our inspection and were getting to know the service and teams. The head and deputy head of midwifery were not at work at the time of our inspection.

The service had an obstetric and board level safety champion and the champions met regularly. Due to changes within the care group's senior leadership team, there was no midwifery champion in place. There was no evidence ward level champions were in place. Senior leaders reported these had been hard to recruit to during the Covid-19 pandemic.

Vision and Strategy

The care group had a vision for what it wanted to achieve and a strategy to turn it into action, however maternity staff had not been engaged in the development. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service provided a vision and strategy as part of the Healthy Lives Care Group, which was part of the business plan for 2022-2025. The vision described working with people in need of services, carers, communities, locality partners and staff to develop a system approach that continued to offer more innovative, community-based services, enhanced experience of services, improved population health, improved staff experience at work and provided services that were efficient, effective and value for money.

The care groups had outlined five priorities and intentions to work towards to enable them to fulfil their vision. These included areas such as utilising data and feedback, building a culture of respect encouraging innovation and making every contact count.

The trust provided evidence of a maternity vision and strategy, however, the vision was not locally developed and we saw no evidence staff were engaged with the care group vision.

Culture

Staff were focused on the needs of patients receiving care. The service had worked on improving the culture.

Staff reported the culture in the department had improved over the last six months however they shared concerns around plans for leadership of the service going forward. The delivery suite had worked on improving the relationship between medical and midwifery staff with a psychological safety programme within the department. A promoting positivity board was displayed in staff areas and the team were encouraged to share positive feedback.

The 2021 staff survey highlighted the service scored below the trust and care groups averages for several areas including a compassionate culture, leadership and inclusion. The ante/post-natal unit scored the lowest for the care group for recognition and reward and all areas within the service scored below the trust and care group averages.

For a health and safety climate, again the ante/ post-natal unit scored the lowest in the care group and both services scored below the trust and care group averages. Overall, the antenatal and post-natal unit scored lowest across the healthy lives care group and obstetrics (combined with gynaecology) was below the care group average and the sixth lowest out of 30 services. Senior leaders told us action plans to address concerns had yet to be developed. We saw board reports had identified further work needed to be done within ante/ post- natal areas.

Maternity

Staff we spoke to told us they knew how to report incidents, however we did not see evidence that learning from incidents was routinely updated and shared on the wards. The service had recently been supported by the freedom to speak up guardian and recent cultural concerns had been addressed by changes in the senior team. Staff we spoke to were positive about their recent involvement and plans were in place for the guardian to be available to speak with additional staff during departmental meetings.

Governance

The service shared information with external organisations, however leaders did not always operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.

We found there were unclear processes of how ward to board assurances were gained about the quality and safety of services. Staff could not always articulate the governance framework for the directorate and how information flows between directorate and the board.

Monthly care group safety meetings were held where incidents, learning and risk were discussed.

Seniors leaders we spoke to said information was shared to staff through ward managers. Ward managers told us team meetings were held but there was no set format or frequency for these. Data we reviewed showed each area had minutes for only one meeting in the last year and there was no record of any staff attendance. Daily ward meetings did not routinely cover safety or performance.

The service engaged with external organisations and reported any notifiable incidents to relevant bodies including the Health and Safety Investigation Brach (HSIB). Deaths within the service were investigated, where appropriate, using the perinatal mortality review tool, discussed at perinatal mortality review meetings and reported externally in line with national recommendations.

The service was meeting seven out of the ten requirements of the NHS Resolution Maternity Incentive Scheme at the time of submission. The Maternity Incentive Scheme (MIS) is an incentive for trusts to meet a set of actions that are focused on improving the safety of services. Action plans were put in place to address the outstanding areas and at the time of the inspection the service reported they were compliant in an additional area. Elements of the requirements had been reported as being met but we saw evidence these were not being implemented in practice, for example the use of hourly fresh eyes monitoring of fetal heart rate.

The service had an escalation processes which was integrated into local maternity systems. The process involved two stages with the first being internal escalation. For the period August 2021 to May 2022, the service had triggered the internal escalation policy 29 times. There had been no external escalation for the same period with no unit closures.

The Ockenden review was an independent review of maternity services that was carried out to identify areas for improvement across midwifery service. The final report was published in March 2022 and outlined 15 areas of immediate and essential action that expanded upon actions issued in earlier reports. The service reported they were partially compliant with 13 of the actions and fully compliant with one action. One action had no response.

Management of risk, issues and performance

Systems were in place to manage performance however these were not accessible to all staff or utilised effectively. Risks for the service were not always accurately recorded or updated.

Not all managers had insight into the availability of a local maternity system dashboard and although local dashboards were in place, these were not easily accessible to staff and we did not see this was used routinely to monitor and improve performance.

The service had an obstetric and board level safety champion and the champions met regularly. Due to changes within the senior leadership team, there was no midwifery champion in place and there was no evidence ward level champions existed. Senior leaders acknowledged these had been hard to recruit to during the Covid-19 pandemic.

Obstetric risks were recorded on a trust wide risk register with six risks being listed at the time of the inspection. Controls for the risks were detailed however for five out of six of the risks no dates were associated with these to provide a timeline or target. This meant the trust could not see if progress made was timely from the entry, when actions were overdue, or when the last update was made. For the risks of hypernatraemia due to poor feeding and increased weight loss, controls had been in place since 2019, and the controls had not been updated since June 2021.

Managers for the service reported different risks to those within the senior leadership team. For example, mangers identified a lack of infant feeding midwifes as a risk, this was not reflected on the risk register and whilst a risk had been identified for failing to achieve targets for breast feeding, controls did not reflect current practice with 'infant feeding midwives in post'. Other controls were in place including training of staff but again this was not dated.

Information Management

The service collected data and submitted notifications to external organisations as required, however there were gaps in data collected. All staff could not readily access data in accessible formats to help understand performance, make decisions and improvements.

The service had a mixture of paper and electronic records. Most of the records we reviewed were paper however some areas were mixed with paper and electronic records, including prescription charts.

The service submitted data to the Maternity Services Dataset to help in identifying areas that may require local clinical quality improvement.

One to one midwifery care in labour and a dedicated labour ward coordinator are recognised staffing measures to help improve outcomes for women and babies and a requirement of the MIS. Despite this the service did not collect data on compliance with supernumerary status of the labour ward coordinator.

The service used an acuity tool on ward 22 and the delivery suite with data entered six times a day. The tool used real time assessments of staffing levels in relation to the women's care needs and monitored red flag data. We were not assured the service was utilising the outcome from the acuity tool effectively, no red flag reports were available and staff in some areas reported being unsure if the data they were entering was correct. Staffing incidents were reports

The service reported incidents to the national reporting and learning system (NRLS) and serious incidents to the strategic executive information system (StEIS). Qualifying incidents were reported to HSIB.

The service presented performance information in several different formats, including a Maternal Perinatal Quality Surveillance report, Perinatal Quality Oversight Group Highlight Report and a local performance dashboard. The service

also had quality and safety dashboards which showed data including FFT response rates, hand hygiene, falls and pressure ulcers. Managers we spoke to reported performance dashboards were not easy to access and weren't routinely referred too. Awareness of quality and safety dashboards was greater however displayed information was often out of date.

Engagement

The service recorded compliments received from patients. Plans were in place to restart engagement through the Maternity Voices Partnership.

Women could give feedback about the service directly; by raising concerns, complaints and compliments. They were also able to offer feedback through friends and family test (FFT) surveys and maternity services social media pages.

The FFT gives patients the opportunity to submit feedback on their care using a simple question which asks how likely they are to recommend the service to their friends and family. For the period August 2021 to February 2022, the service overall received positive feedback that was below the target of 95%.

The service did not have an MVP at the time of the inspection however plans were in place to recruit to vacant roles to restart the local group and engage with the community.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

The service encouraged staff to develop the service, the Elm team had been created to provide continuity of care for women undergoing a planned caesarean section. The team was created in response to the Covid-19 pandemic but had continued due to positive feedback from staff and women using the service.

The service had two research midwives and was taking part in several trials including

- COPE; the Carboprost or Oxytocin Postpartum haemorrhage Effectiveness study which was looking at the treatment of post delivery bleeding.
- The Parrot- 2 trial which was looked at repeat placental growth factor-based testing for women with suspected preterm pre-eclampsia.
- Big Baby Trial which looked at the Induction of labour for predicted macrosomia.

Services for children and young people

Good ➔➔

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.

Staff received and kept up-to-date with their mandatory training.

All staff groups across services for children and young people met the mandatory training target of 90%; in March 2022 compliance was 97.88% for registered nursing staff, 95.48% for medical staff, 97.73% for additional clinical services staff and 96.97% for administrative and clerical staff.

The mandatory training was comprehensive and met the needs of children, young people and staff.

Clinical staff completed training on recognising and responding to children and young people with learning disabilities and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect children, young people and their families 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.

Nursing staff received training specific for their role on how to recognise and report abuse.

Medical staff received training specific for their role on how to recognise and report abuse.

The trust target for safeguarding children level 3+ was 80% and this was achieved across all staff groups who were required to complete it.

All staff were required to complete safe child level three modules, training compliance across all staff groups was 99% for the foundation module and 96% for the update. The trust target for this module was 100% which was not achieved. Band six allied healthcare professionals compliance was 73% and band seven allied healthcare professionals compliance was 87% for the safe child update module, all other staff group achieved 90% or higher compliance.

All other safeguarding training modules had a 100% compliance target. We looked at the training figures and saw that across all modules, there was a 98% training compliance rate.

Services for children and young people

Overall compliance varied between staff groups; for additional clinical services staff compliance was 99%, for medical and dental staff and allied healthcare professionals compliance was 94%, and for registered nursing and midwifery staff compliance was 98%. Although the trust target was not met, we saw high levels of training compliance across all staff groups and most modules.

The trust had a safeguarding children policy; it was in date (issued in June 2020), version controlled and was due for review in June 2023. The policy signposted staff to other related policies and included links to external sources and resources to support staff to keep children safe.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

The trust had a child abduction policy; it was in date (issued in January 2019), version controlled and was due for review in April 2023. The policy included specific actions staff should take in the event of a missing child, and signposted staff to other related policies and included links to external sources and resources to support staff to keep children safe and detailed clear roles and responsibilities for staff in the event of an incident. We saw examples of abduction prevention, as per the trust policy, including locked doors to ward areas with a Proximity Access Control (PAC) system for access and facilities for parents to stay with children and babies overnight.

Due to the COVID-19 pandemic, the trust had not undertaken a simulation of a child abduction in the reporting period, however we saw this had been reported at board level, and there were plans in place to recommence scheduled simulations.

The trust had a named doctor and nurse for safeguarding for children; they provided governance, leadership, education and support to staff. We saw they had implemented many improvements to the trust's monitoring and management of safeguarding and had focused to make both process and patient experience improvements. During the inspection, the named safeguarding professionals told us about the several initiatives that had taken place which included presenting at conferences, formal child protection clinics in a dedicated child protection suite and improvements to patient information leaflets (PILs). The safeguarding team had also completed a gap analysis to identify areas of improvement in the RCPCH child protection service standards (2020) and had completed all required standards.

The trust had completed audits in both adult and children and young people's areas with a focus on safeguarding children; we saw there were processes in place to learn and make improvements across areas and to embed children's safeguarding as everyone's business. The safeguarding lead doctor and nurse continued to support the embedding of learning and new practice across areas.

Cleanliness, infection control and hygiene

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

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

The service generally performed well for cleanliness. The service completed hand hygiene audits in April 2022; we saw that all areas of services for children and young people were 100% compliant. This had improved from an audit completed in September 2021, where compliance with hand hygiene on the children's ward was 91%.

Infection rates in children and young people was low and there had been no outbreaks of infection; the trust had reported three infections in the last 12 months required by mandatory surveillance and one was healthcare associated, which received appropriate investigation. There were infection surveillance processes in place which included targeted investigations.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that ward areas were clean, tidy and free of clutter.

Staff followed infection control principles including the use of personal protective equipment (PPE). The trust used national guidance documents during the COVID-19 pandemic and did not develop local policies, therefore standalone policies did not required updates.

The trust had two training modules for infection prevention and control; compliance across all staff groups was at 94%, which was just below the trust target of 95%. All staff who were required to had completed level one training. Two staff groups out of four did not meet the training target for level two infection prevention and control training; allied health professionals compliance was 90%, and medical staff compliance was 77% compared to the trust target of 95%.

Staff cleaned equipment after patient contact.

The trust had three policies for infection prevention and control including a hand hygiene policy; they were in date and version controlled. All were due for review in the months following the inspection and the trust told us that they had plans in place to implement the national infection prevention and control manual, which was going through their governance processes and would replace the stand alone policies. The policies included guidelines and roles and responsibilities for staff, including "5 moments for hand hygiene", a prompt for staff to promote opportunities for hand hygiene, hand hygiene techniques and responsibilities for staff groups. The policies also outlined assurance processes and accountabilities, which included monitoring mandatory training and regular audits.

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, staff did not always carry out daily equipment checks in all areas and there were some out of date items of stock.

Children, young people and their families could reach call bells and staff responded quickly when called. During the inspection we saw that children, young people and their families were responded to in a timely way.

The design of the environment followed national guidance. There were appropriate locking systems on entry to children’s areas, and we saw specialist equipment for children and young people was available.

However, the milk fridge and freezer on the neonatal unit was not locked. The fridge freezer was housed in a lockable room, but we saw the door was wedged open on the first day of inspection. This was escalated to the nurse in charge at the time. On the second day of inspection, the room with the milk fridge was again wedged open. This was not in line with national guidelines. We reviewed the trust's policy on the storage of expressed breast milk and although it was in date, the policy did not reflect national guidelines.

The service completed an environmental audit on ward 15 in September 2021 which showed poor levels of compliance at 58% and included issues in cleaning, tidiness of the ward, damaged furnishings and stock issues. The audit acknowledged the pressure the ward had been under at the time of the review. We saw these issues had been rectified during the inspection. In response, recommendations had been added to an action log with an overall deadline for completion, however the actions were not always clearly defined and there were not always owners or deadlines allocated to each action. It was unclear from the information provided how the service monitored the improvements required.

Staff did not always carry out daily safety checks of specialist equipment. During the inspection we saw gaps in a daily checklist for the resuscitation trolley in the children's outpatient department. Gaps were seen on 08 February, 18 February, 17 March, 22 April and 27 April 2022. We also saw gaps in the daily checklist of the resuscitation trolley in the children's surgical day section of the paediatric ward on 18 and 20 April 2022. We also saw items of out of date stock in the resuscitation trolley in the outpatient department. We identified from the documentation there had been three items of out of date equipment on the trolley. They were identified as expired in February and April 2022, however when we checked the stock two of the three items were in date but the documentation had not been updated. The third item had expired in April 2022 and had not been replaced. We escalated this to the nurses on shift at the time of the inspection. Due to the location of outpatients, there were no other nearby paediatric areas that would be quickly able to provide this piece of equipment if needed in an emergency resuscitation situation. This was a risk to patients because the service could not be assured that medicines and equipment required in an emergency were checked and documented thoroughly and were available.

The service had suitable facilities to meet the needs of children and young people's families. We saw there were different areas on the children's ward, including playrooms for younger children and an adolescent room for young people, which included access to games consoles. There were sensory items available for use.

The service had enough suitable equipment to help them to safely care for children and young people.

Staff disposed of clinical waste safely.

The service had an equipment maintenance log to monitor when equipment needed to be scheduled for maintenance and testing; across all areas of services for children and young people that we looked at; there were no items overdue.

The trust had completed fire inspections of all children and young people's departments between August 2021 and February 2022; three areas out of six did not have copies of local fire drills and inspections completed and located in the department. The trust told us they had action plans in place to ensure these were undertaken.

The trust had completed an evacuation training exercise in December 2021; improvements, recommendations and actions were documented, and none related specifically to the children and young people areas of the hospital.

Services for children and young people

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration. However, policies and procedures were not in place to monitor and manage restraint of children and young people in the service.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately.

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

The service used paediatric early warning scores (PEWS) to monitor children and young people and to recognise and respond the deterioration. There was no nationally recognised guideline at the time of the inspection, so the trust had developed their own PEWS tool using appropriate national recommendations to ensure all children and young people were monitored and treated safely.

There was a referral process in place to transfer children to another local hospital, and the trust's policies included a paediatric escalation algorithm to support staff to stabilise children and young people while they awaited transfer. Staff we spoke with told us that they could also get remote clinical advice about a deteriorating child if needed, and they had good relationships with the transfer provider.

The service had a policy for recognition and response to acute illness in children and young people in hospital; it was in date (issued in June 2021), version controlled and was due for review in June 2024. This was put in place after CQC raised concerns through our engagement that the trust had no referral policy in place for transferring children and young people to another service.

It outlined the process for escalating concerns in children and young people's presentation or condition and included a PEWS escalation algorithm, flow charts and contact telephone numbers. The policy also included a standard operating procedure for staff to follow which incorporated the PEWS, paediatric sepsis six, escalation planning including SBAR (situation, background, assessment, recommendation) handover communication tool and paediatric pain tools.

The service completed audits to check that PEWS had been recorded correctly in the children's ward and CYPED (day unit) areas. The last audit was completed in April 2022, where 20 records were checked across both areas and showed 100% compliance on ward 15 (Children's ward) and 97% compliance in CYPED; this met the trust target.

The service had agreed processes to manage children and young people who deteriorated and required transfer to a paediatric intensive care facility. Staff at the service could access clinical protocols and checklists to support managing a critically ill child while arrangements for transfer was made.

The service had policies for the onset and management of sepsis in neonates and children. Both policies were in date and version controlled. The neonatal policy was based on National Institute of Clinical Excellence (NICE) guidelines and quality standards and displayed risk factors for neonatal sepsis and guidelines for management. The children's policy outlined the modified paediatric SIRS (systemic inflammatory response syndrome) criteria which was used as a screening tool for sepsis in children. The policy included a flow chart which included details of the paediatric sepsis six treatment model and appropriate timescales for treatment which was in line with national guidelines.

Staff knew about and dealt with any specific risk issues. We looked at patient records during the inspection across ward areas and saw that appropriate risk assessments had been completed.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). However, this was provided by an external service and staff told us there were delays in face to face assessment. The service used their own processes to keep children and young people safe until they were able to be assessed.

We asked the trust for their policy on restraint for children and young people and they told us there was no child restraint policy as children were managed in the least restrictive manner. However, staff we spoke with gave examples of children and young people who attended the ward who required physical restriction or barriers to prevent harm to themselves, others or property. We were concerned that there was no policy or guideline for staff to follow to provide physical restraint in a safe way when required, and this meant there was a risk that inappropriate techniques or practices may be used by staff. There was no system in place by the trust to monitor and manage restrictive practices.

The trust told us that staff within CYP had 100% compliance for conflict resolution training. There had been no reported incidents relating to rapid tranquilisation of children or young people in the last 12 months, and they were developing a standard operating procedure for clinical holding when a child or young person is undergoing treatment, however this did not address clinical holding or restraint outside of clinical procedures, for example physical restraint to protect children and young people from harming themselves and others.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. The service used a partner organisation to transfer children and young people with a time sensitive condition if they presented at the hospital or deteriorated to paediatric and neonatal intensive care units. Staff had access to checklists and procedures to support them to stabilise and prepare the child for transfer.

Shift changes and handovers included all necessary key information to keep children and young people safe. Staff used SBAR (situation, background, action, result) as a tool to handover key information between shifts and staff groups. We saw examples of this used during the inspection.

The service had a policy for end of life care for children and young people, which was in date, version controlled and due for review in November 2023. The policy included information to support staff to recognise, manage and plan for children and young people with life limiting and life-threatening conditions, including advanced care planning.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families 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. However, there were a number of speech therapist vacancies across the services.

The service had enough nursing and support staff to keep children and young people safe. During the inspection we saw there were enough staff to meet the needs of patients and provide the care and treatment in their care plans, and when we reviewed staffing data, we saw minimal registered and unregistered nurse vacancies. There was 1.15 band six whole time equivalent (WTE) vacancy for registered nurses and 3.20 band four health care support vacancies across services for children and young people.

However, we saw there were a number of speech therapist roles across the community children's services that were vacant and these vacancies had impacted specialist in reach services on the acute ward. The community service had an average of 19.19 WTE vacancies across nursing and support staff as at 31 March 2022. This was mitigated by over recruitment in some roles. However, there were 5.61 WTE vacancies in allied health professional's speech therapist roles out of 92.09 budgeted WTE posts. We saw this issue was on the service's risk register and had been recently reviewed and it impacted on the availability of speech therapists to contribute to multidisciplinary team (MDT) meetings for children on neurodevelopmental pathways in the service. The service had ongoing recruitment. We did not see information or evidence that the staffing shortfalls affected the children's ward service.

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. The service had implemented the Royal College of Nursing guidance on staffing general acute paediatric rotas; we saw the service had reviewed staffing and collected appropriate data dets to calculate the staffing requirement which had resulted in an uplift of 2.29 WTE staff in October 2021. National guidance recommended a skill mix of 70/30 registered/unregistered nurses, and the service skill mix was staffed at 67/32 which was based on this guideline.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Managers across services for children and young people had a daily huddle where they discussed staffing. If staffing numbers were low in one area, staff could be moved to provide safe staffing numbers.

The number of nurses and healthcare assistants mostly matched the planned numbers.

The vacancy rate was 8.70%. The trust did not have a target vacancy rate; they told us they actively recruited to all vacant posts.

The service had low turnover rates compared to the trust target. The trust's target for turnover was 10%; the service had a turnover rate of 0% for nursing staff in March 2022.

The sickness rate was 5.94%; this was higher than the trust target of 4%.

The service had low rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that staff who worked on the wards often picked up extra shifts when cover was needed, and they rarely used agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service. Most agency staff used had worked at the service before; managers told us they had a local induction and had a walk around before starting an agency shift.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to match the planned numbers. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to match the planned numbers.

Services for children and young people

The service had an average of 2.95 whole time equivalent (WTE) vacancies across medical staff as at 31 March 2022. However, there were 4.73 WTE vacancies in consultant roles out of 18.15 budgeted WTE posts, which is approximately 26%. There was some mitigation in place by over recruitment of speciality registrar roles by 1.53 WTE although this was not a consultant level doctor. We saw this issue was on the service's risk register and had been recently reviewed, however there were not enough senior decision makers to fill the medical staff rota.

Staff we spoke with told us that consultant staffing was a risk for the department. There were rota gaps in the consultant rota that were covered by substantive staff.

The vacancy rate was 5.94% for medical staff. The trust did not have a target vacancy rate; they told us they actively recruited to all vacant posts.

The service had a low turnover rate for medical staff. The trust's target for turnover was 10%; the service had a turnover rate of 0% for medical staff in March 2022.

Sickness rates for medical staff was low. The trust reported no sickness for medical staff.

Managers could access locums when they needed additional medical staff. We saw locum staff on the rota during the inspection who were known to the service.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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

The service was compliant with UK working time regulations for medical staffing which was in line with RCPCH standards.

Records

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

Patient notes were comprehensive and all staff could access them easily. We looked at records during the inspection and found they were completed appropriately, in line with best practice and trust guidelines.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The children’s day unit and emergency department was co-located as the CYPED (children and young people’s emergency department); the departments had worked to streamline their records so they were completed consistently across both areas. This supported staff, who worked across both areas, to reduce the risk of errors.

Records were stored securely. We saw paper records were stored in locked trolleys on the wards, and computers were locked when not in use where electronic records were used.

The service had completed a records audit where overall compliance was noted as 98.4% in February 2022, however, we did not see how many records from each area was reviewed. The audit was part of a records improvement plan, and we saw that action was documented when compliance was low.

Services for children and young people

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, however staff did not always follow them. Medicines reconciliation was not always completed in line with the target.

The service had systems and processes to prescribe and administer medicines safely. However, staff did not always follow them. During the inspection, on the paediatric ward we saw one bottle of antibiotic that was passed its use by date. Staff had prepared a new bottle to use, however the out of date bottle had not been disposed of in line with guidelines. We also saw on the Special Care Baby Unit (SCBU), one bottle of Human Albumin Solution that had passed its use by date and had not been disposed of in line with guidelines. This was a risk to patients as the likelihood of an out of date medicine being used by staff increased when they were stored alongside in date medicines.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines.

The trust collected medicines reconciliation data as part of an automated monthly data capture. Medicines reconciliation means that people who go into hospital as inpatients had an up-to-date list of their medicines in their hospital record and national guidelines state this should be completed within 24 hours. In March 2022, 84% of medicines were reconciled within 24 hours of admission for paediatric patients. This was below the trust target, which was in line with national targets, of 90%. We asked the trust to provide any related action plans to make improvements; they told us that the trajectory was improving, and was monitored and escalated appropriately, but they did not provide action plans to demonstrate how they planned to make improvements.

Staff completed medicines records accurately and kept them up-to-date. We reviewed medicines records as part of the inspection and found no concerns.

Staff stored and managed all medicines and prescribing documents safely.

The service ensured people’s behaviour was not controlled by excessive and inappropriate use of medicines. Leaders told us the trust did not use rapid tranquilisation to control behaviour.

Pharmacy staff told us about quality improvement initiatives they were working on in children’s services, including standardising a medication form from liquid to dispersible so that when children and young people move back in the community, the supply was easier to obtain.

Incidents

The service managed patient 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 children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, we saw that duty of candour was not always completed in line with regulation.

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 gave examples of reporting incidents during the inspection and knew the process to follow.

The service had no never events on any wards.

Services for children and young people

Managers shared learning with their staff about never events and incidents that happened elsewhere. Managers had created a monthly one-page newsletter that was shared with staff across all areas of services for children and young people which included learning and themes and specific actions from incidents. We looked at three most recent months newsletters and saw this included the top three themes of incidents, and specific messages shared relating to incidents.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Managers told us they involved other agencies in investigations if the child or young person had crossed services; they also investigated incidents across areas of the hospital as a team.

Staff met to discuss the feedback and look at improvements to children and young people's care. The service had a weekly paediatric safety meeting where incidents, lessons learned, and duty of candour were standing agenda items. We looked at three recent sets of meeting minutes and saw there was a mixture of staff grades and roles present at different meetings and incidents were discussed routinely. The service had no lessons learned to share in the minutes we looked at and there had been no incidents requiring duty of candour to be considered.

The service held monthly mortality and morbidity meetings; medical staff met to review clinical cases and discuss any learning or improvements that could be made. We looked at the minutes of the three case reviews and saw attendance was high (17 out of 20 medics attended), cases were discussed in detail and recommendations identified.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong.

However, we reviewed the most recent serious incident investigation report for services for children and young people. The report identified two care and service delivery issues, but only one of these was addressed by the action plan. The action plan contained one action which was due for completion by 31 January 2022; the action plan had not been updated to reflect progress and we were not assured there were systems in place to monitor and manage action plans from the information provided. We asked the trust for an updated action plan, and although we could see evidence that the one action was monitored, the second recommendation had not been reviewed or actioned.

The duty of candour regulation ensures that providers are open and transparent with people who use services and other 'relevant persons', and it requires duty of candour to be applied to all notifiable safety incidents.

Duty of candour was noted as "not applicable" in the incident report we reviewed, which was not in line with regulations. Following the inspection, the trust told us that this had been documented in error, however the evidence they provided continued to state that duty of candour was not applicable. Furthermore, the trust provided the letter sent to meet the duty of candour regulation which we reviewed following the inspection and saw that an appropriate apology had not been documented.

Managers debriefed and supported staff after any serious incident. Staff told us that when incidents occurred there were debriefs and the teams were supportive to each other.

Managers took action in response to patient safety alerts within the deadline and monitored changes.

Services for children and young people

We saw that there had been a simulation in maternity services which included neonatal staff in February 2022; 40 staff across maternity, neonates, theatres and anaesthetics attended and there was positive feedback from staff who gained awareness in different roles and constructive feedback was given and the services identified lessons learned.

The service had developed a safety and quality dashboard which included the metrics that had been used when safety thermometer was mandatory to complete. The metrics were updated daily which meant that the service could monitor the metrics more regularly. The dashboard for paediatrics covered the children's ward (ward 15), SCBU (ward 23), paediatric day unit and paediatric outpatients, as well as paediatric services at other locations, therefore it was combined across the trust.

There had been no infections, falls or pressure ulcers in the seven days prior to the inspection and there had been one medication administration error in the same period.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Most policies were up to date, however we saw one policy that did not reflect best practice guidelines relating to the storage of breast milk. We raised this with the trust during the inspection, and saw the issue was added to the risk register and the service were putting plans in place to mitigate it.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We observed handovers during the inspection and saw examples of staff discussing the needs of both children and young people in their care and their families.

The trust monitored venous thromboembolism (VTE) risk assessment completion and compliance as part of the trust wide audit. We asked for evidence of compliance with VTE assessments, but the trust did not provide it. The trust had explored developing a local CYP VTE guideline and had made contact with another local trust to start its development; this was not yet in place.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. In CYPED there was a trolley in the waiting area with snacks and drinks that were available at all times.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. The service used STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) as a tool to screen the nutrition of children and young people.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. The last STAMP audit was completed in May 2022 on ward 15 (children's ward) and compliance with the audit was 100%.

Specialist support from staff such as dietitians and speech and language therapists (SALT) was available for children and young people who needed it, however there were vacancies in the SALT team.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Children and young people received pain relief soon after requesting it. We observed staff using distraction techniques with younger children to help manage their reactions to procedures that might be painful. The children's ward had play therapists in the staffing skill mix to support with this and we saw that they were also utilised in the day surgery part of the ward to distract children and young people and support sedation.

Staff prescribed, administered and recorded pain relief accurately. We reviewed records during the inspection and had no concerns about pain relief. Staff used pictorial pain charts to support recording pain levels in children and young people.

In CYPED, which included the children's day unit, the service had completed a records audit in April 2022 which included the recording of pain scores 80% (eight out of 10) records had a pain score recorded. There had been a decline since the audit one month earlier, where the pain score was documented in 90% of the 10 records reviewed. However, the service had a pain guideline that was going through the approval process and was documented as an action to make improvements.

Compliance for recording pain scores on the children's ward (ward 15) was 100% in April 2022. During the inspection, we saw pain scores were appropriately completed in the records we looked at.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service was working towards accreditation by relevant clinical accreditation schemes.

The service contributed to relevant and required national audits.

The service had an audit plan for 2021/2022 and we saw that included mandatory national audits, local audits and NICE audits. There were 10 audits in the audit plan and one was carried forward from 2019. Due to the COVID-19 pandemic, these audits were not all completed, therefore the trust had not yet requested future audit plans, to allow completion of the previously planned audits.

We reviewed the most recent outcomes and saw that where there were improvements to be made, there were action plans in place, or actions had been taken to address areas that did not meet the required standards. The service had some issues with data quality in one audit which was not recognised until the third round of data submissions, however, once identified improvements were made and the service expected to see an improvement in outcomes. Due to the COVID-19 pandemic, not all audits had taken place or been reported on during the inspection period, however the trust told us they had reports in progress and were on track with data submissions.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards.

Managers and staff used the results of audits to improve children and young people's outcomes.

The Children and Young Persons (CYP) team participated in the following accreditation programmes; Bliss for babies born premature or sick, Bliss Locked Out programme, National Neonatal Audit Programme (NNAP), Clinical Quality Accreditation Framework. There were improvement plans in place to address the requirements of both BLISS audits and the NNAP audit. We saw that the improvement plans had clear actions that were monitored on the improvement plan and we saw regular documented updates, including dates when actions were completed.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The trust's quality lead nurses completed assurance visits to review wards. Ward 15 (children's ward) had received a visit in March 2021, 313 positive observations were made out of 342 total observations, 29 were negative. The ward received an overall performance score of 91.52%. Ward 23 (SCBU) had received a visit in April 2021, 277 positive observations were made out of 292 total observations, 15 were negative. The ward received an overall performance score of 94.86%. Both wards received the most negative observations in safeguarding. The wards were invited to a quality reference meeting in the following months where they were required to present action plans to address the issues found during the visits. We asked to see actions related to the accreditation schemes the service participated in, but the trust did not provide them for these quality assurance visits. Following the inspection, the trust provided minutes from the quality reference meeting which confirmed that actions had been followed up by the service areas and improvement plans were in place.

Competent staff

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. However, appraisal rates were below the trust target.

The clinical educators supported the learning and development needs of staff. We saw that they had been addressing gaps in different staff groups. During the inspection, student and newly qualified nurses were engaged in a training day to address any gaps they felt they had in their knowledge, skills or experience as a result of the COVID-19 pandemic. The clinical educators had developed bespoke training as a refresher in sepsis and deteriorating patients to address gaps from reduced activity during the pandemic; this was delivered to all nursing staff.

Services for children and young people

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families.

Managers gave all new staff a full induction tailored to their role before they started work.

Overall, in services for children and young people, staff appraisal rates averaged 82.14% which was below the trust target of 95%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work, however the appraisal rate did not meet the trust target of 95%. Registered nursing staff were almost at target, with an average of 92.19%.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff appraisal rates were particularly low, at 51.79% in March 2022 and we did not hear about plans to improve appraisal rates for medical staff during the inspection. However, following the inspection, the trust provided us with more up to date appraisals data for medical staff which showed that as of April 2022, 84% of medical staff in the service had received an appraisal. This was still below the trust target of 95%, but showed an improvement in compliance.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meeting notes were shared in staff rooms and ward managers discussed important updates or shared learning in daily staff huddles, which we observed during the inspection.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw staff training days during the inspection.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. We asked ward managers about poor performance and they gave examples of actions they would take to support improvement, including supporting training requirements and supervision.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

Staff from multidisciplinary teams met to discuss diabetes management and service improvement. The meetings were scheduled quarterly, and we looked at the two most recent sets of minutes, however the last meeting had been in November 2021 and we did not receive minutes for the planned January 2022 meeting.

We saw that staff worked together across areas of services for children and young people and the staff we spoke with told us they felt supported by other areas

We spoke to leaders in each area as part of a focus group during the inspection and found that staff were positive about relationships that had been developed between areas to make improvements for children and young people.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff told us consultants led daily ward rounds on all wards, including weekends. Children and young people are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. They displayed posters to access leaflets online in the children's ward, and parents told us they received appropriate information for the child.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff clearly recorded consent in the children and young people's records.

The service had completed an audit of consent for elective procedures for patients seen between October 2020 and March 2021. Most areas of the audit showed 100% compliance, however the audit found there was no evidence of

information leaflets and copies of consent forms being given to parents. The service developed an action plan to address these issues which included sending information leaflets by post with appointment letters and filing the second copy of consent forms if a parent declined. These actions were due to be completed in February 2022 and the trust planned to re-audit to check they had been implemented, however the action plan we received had not been updated so we saw no evidence that the actions had been completed in the required timescale, or that a re-audit had been completed.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff could describe their actions if a parent or guardian was unable to consent or if there were concerns about their capacity to do so.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed staff using distraction techniques, singing songs and playing with young children to provide the care and treatment they needed.

Children, young people and their families said staff treated them well and with kindness.

Staff followed policy to keep care and treatment confidential. Doors were closed or curtains drawn while staff were treating children.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients were happy with the service provided, or where improvements are needed. The service had received positive FFT scores (good or very good) in every month from October 2021 to April 2022. However, the trust did not record response figures for the children's day unit, which was co-located and run with CYPED.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Services for children and young people

Staff gave children, young people and their families help, emotional support and advice when they needed it. We spoke with parents of babies who were being cared for on the special care baby unit (SCBU) who told us about their experiences on the ward, which included being supported to stay with their babies, explaining complex equipment and helping them to manage their own anxieties and worries during their child's stay on the ward.

Staff supported children, young people and their families who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff on the children's ward told us that they could allocate children and young people to single rooms if they needed to, in order to provide privacy.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing. There were facilities for parents to stay with their children on both the children's ward and SCBU. We heard one example where the staff in SCBU had set a cot bed up for a parent in their baby's room next to the nurses station so that they could stay overnight and the baby's monitoring and observations could be completed by the nursing staff, while they were close by.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children, young people and their families to make advanced decisions about their care.

Staff supported children, young people and their families to make informed decisions about their care.

Patients gave positive feedback about the service.

A satisfaction survey for parents of babies who were cared for in the SCBU (Ward 23) was completed between October and December 2021; parents fed back they felt informed, were supported by staff and were kept up to date on their babies condition, however some respondents (8% out of 14 respondents) felt they were not able to speak to senior decision makers, or be involved in making decisions for their baby. The service also collated qualitative feedback during this survey which included comments like "The care we received is so hard to put into words. We were given the best care & love & support, true angels in disguise. We could never thank you all enough. We will never forget the exceptional care we received" and "all staff have been so welcoming, they have provided the best care to my baby & myself. Felt involved within my baby's care, everything was explained clear".

Is the service responsive?

Good 

Services for children and young people

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. We looked minutes of a cross sector meeting that senior staff attended, which included local NHS, primary care and commissioning services, where we saw that local pathways and issues were discussed and actions agreed to address the items on the agenda. This meant the service leaders were working with local partners to plan and deliver services.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered. The CYPED, which had a co-located children's day unit, had been developed with input from local school children and the decoration was suitable for children of different ages.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The trust's policy was that young people aged 16 and over were seen and treated in the adult wards and departments, however if young people were still under the care of a paediatrician, they could continue to be seen in the paediatric areas of the hospital.

Managers monitored and took action to minimise missed appointments and ensured that children, young people and their families who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat children and young people in a day. The children's day unit had been co-located with the children's emergency department which meant that children and young people could move between areas for investigations, without needing to leave the department. This provided a more streamlined service to children, young people and their families.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of children, young people and their families. We saw there were play rooms, adolescent rooms, sensory equipment and child friendly displays and decorations in the departments we inspected. Play specialists and support staff used available equipment and their training to support children who displayed anxieties or who had additional needs.

Staff used transition plans to support young people moving on to adult services. Children and young people aged 16 and under were seen in the paediatric areas of the hospital and this was included in the trust's admission policy. Those who were aged over 16 were seen on adult wards and departments. This was reflected in the trust's policies.

Services for children and young people

In March 2022, 3.19% of children and young people aged 0-17 were inpatients on an adult ward; the trust's policy was that children aged 16 and over were admitted to adult wards, unless they were under the care of a paediatrician, and adjustments should be made to meet their needs. During the inspection, we saw only young people aged 16 to 17 were cared for on adult wards.

During the inspection, we reviewed the care of two patients who were under 18 (in line with the CQC framework) and being treated on adult wards. We saw that reasonable adjustments for young people under 18, who met the trust's threshold as an adult; we saw an example of a patient whose parents were unable to stay overnight and felt the adult ward did not meet their needs. The following day, the young person was moved to the children's ward.

Staff supported children and young people living with complex health care needs by using hospital passports. There was also a patient flag that could be used to help staff identify children and young people with special educational needs who may need additional support. There was a learning disabilities link nurse who could be contacted to support the care and treatment of patients.

The local mental health trust provided the mental health and learning disability services to children and young people in the area and staff could signpost patients for specialist support.

The service had information leaflets available in languages spoken by the children, young people, their families and local community.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. There was a translation service available if needed.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

The trust wide referral to treatment (RTT) time in March 2022 was 72 % against a target of 92%. There were 1596 children and young people on the waiting list and 90% of those had an appointment arranged. The trust followed national planning guidance and had no paediatric patients waiting over 104 weeks, nor any predicted to wait over 78 weeks. There was a plan in place to support the recovery of paediatric waiting lists which included the recruitment of additional medical resources with specialist interests in allergies or gastroenterology, and a locum consultant. The service had also been in talks with another local NHS trust to provide additional allergy services. The trust was engaging with primary care partners to develop and improve referrals into paediatrics.

In March 2022, 20% of child and young person attendances to the hospital were to adult areas; 79% of these attendances were to outpatients and the data the service provided included community and technician led appointments.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum. When children and young people had their appointments/treatments/ operations cancelled at the last minute, managers told us they made sure they were rearranged as soon as possible.

Managers monitored that children and young people's moves between wards/services were kept to a minimum.

Managers and staff started planning each child and young person's discharge as early as possible. Staff told us they spoke to children, young people and their families about discharges.

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Staff told us that when there were delays to discharge, it was usually waiting for a discharge letter or medications to take home, but the service did not have a particular issue with delayed discharges.

Managers monitored patient transfers and followed national standards. When children and young people deteriorated and required transfers by the partner provider, each transfer was retrospectively reviewed, and the trust held quarterly joint meetings to review transfers and any learning that could lead to improvements. We saw evidence robust discussion relating to completed referrals, included those children and young people that were transferred, which included discussion about the time to transfer.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

In March 2022, the service had six stage one complaints which was above the trust target of three, no complaints at stage two and one complaint at stage three which was below the trust target of four. There were 20 compliments in the same month. The service categorised complaints and compliments which allowed managers to see the top themes on their dashboard. The top themes in complaints for the service from April 2021 to March 2022 was communication (71) followed by length of time to be given an appointment (27) and delay to diagnosis (22).

Services for children and young people

The service had received 47 complaints between 01 December 2021 and 31 May 2022; they responded to 100% of the closed complaints within the agreed timescale.

The trust had a policy for dealing with complaints, it was in date, version controlled and due for review in September 2023. The policy included flow charts to support staff to follow the appropriate pathway and guidance for joint complaints with other health and social care services.

We reviewed the most recent complaints response that the trust sent to a family and saw that it was appropriate and answered the questions the family had asked. The complaint response also included responses from other organisations who were named as part of the complaint, so we could see the trust had worked jointly, with consent, to provide a holistic response.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it 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 patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff we spoke with spoke positively about ward level leadership. Staff felt supported by ward managers and local leaders and felt they were visible and accessible.

At ward level, shift leaders were experienced nurses who were able to manage the day to day running of the shift. Ward managers supported them to make decisions.

The service had recently added additional band six posts to the nursing structure to provide additional senior cover across all shifts.

The trust had a succession planning initiative called “100 leaders” to support developing staff internally.

Local senior leaders in the service had invested in supporting development of leaders, which included insight sessions to identify staff strengths in leadership and supporting leadership apprenticeships.

Vision and Strategy

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

The care group that services for children and young people was in had a shared strategic vision which was underpinned by partnership working and the aim was to provide responsive, collaborative care.

There were five main priorities: using data and feedback to inform decisions, creating a culture of respect, encouraging innovation, collaboration and co-production, creating empowered autonomous teams and making every contact count to improve the health of the local community.

The care group had formed a listening structure to support staff engagement across areas. The strategy was used as the basis for the care group's next business plan, and was approved in November 2021.

Culture

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

Staff we spoke with during the inspection described the teams they worked in as supportive. We heard there had been cultural issues in the children's areas prior to the pandemic, however, leaders had worked on developing professional challenge skills in the department which we heard had led to more effective conversations between staff of different grades and roles and staff felt that tensions in the department had reduced.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, action plans to make improvements were not always clear or in line with recommendations.

There were governance processes in place and service managers and leaders could describe them and how they fed up to senior leaders and back down again. Services for children and young people sat in a wider directorate called "healthy lives". There were governance meetings in place, and we heard from staff how information and actions were managed and fed into operational meetings to be shared.

However, when we reviewed action plans relating to audits and incidents, we saw that actions did not always reflect recommendations and individual actions were not always documented with specific actions or outcomes, with timescales or action owners. This meant it was not always clear how the service leaders were assured that action plans were effective.

Staff we spoke with were aware of their roles and responsibilities. Leaders and managers told us they had regular opportunities to meet and discuss performance and we saw this in the meeting minutes we reviewed.

There was an annual safeguarding report presented to the trust board which covered the previous financial year. We looked at the report for April 2020 to March 2021; it gave an overview of performance, membership and responsibilities of the steering group, safeguarding children's training performance, key points from the children's safeguarding work plan (which monitored safeguarding related action plans), and developmental work including safeguarding supervision. We saw that safeguarding children was given fair representation in the board report we reviewed.

The service worked with another organisation who provided specialist advice and transfers to children and young people who required treatment at another hospital, for example for high dependency care. We reviewed the most recent

minutes of the service's joint quarterly meeting minutes, and saw they discussed a summary of all cases that were discussed, included those that were transferred. The minutes documented discussion points and agreed outcomes or actions as a result learning from each incident. We saw evidence that outcomes and actions were considered as learning points to be shared with the acute team.

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 risks had actions taken 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 had electronic dashboards that managers used to monitor performance. The trust was in the process of developing "ward boards" which would display the dashboards electronically in the paediatric areas for all staff to view. Managers and leaders told us they used dashboards to monitor themes and trends and identify areas of concern.

We reviewed the risk register for the service. There were six risks documented and the register reflected the risks that leaders told us about during the inspection. The risk register included starting, agreed and target risk levels and we could see that all risks on the register had some reduction from their starting score. However, the risk register did not include commentary or updates relating to mitigating actions that had been taken, or how they had reduced the risk level. We asked the trust to provide this information, and following the inspection the trust provided evidence that the risk register was monitored and updated regularly. The service had documented risk levels had reduced from the initial score on all identified risks.

We saw that a new risk had been added to the risk register as a result of what we found on inspection relating to the accessibility of milk fridges in the SCBU, evidencing that new risks were escalated and added to the risk register when they were identified.

However, the senior leadership team were not aware they did not have a policy for restraint in children and young people; this meant we saw a disconnect between the leadership team within services for children and young people and executive and board level leaders.

The service had a local university complete a peer review of the paediatric department in April 2021. This included a site visit of ward 23, ward 15 and paediatric outpatients and a report of recommendations was produced. The report stated staff were proactive in making service improvements following the last CQC inspection in 2016, and their challenges were in keeping skills up to date and preparedness for sepsis in children and young people. Since the review, the service had implemented a deteriorating children’s policy and PEWS tool.

Information Management

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

The service used electronic performance dashboards which collated performance data. Managers we spoke with knew where to find the information and could describe how they used information from varying sources to make improvements and changes to the service.

Services for children and young people

Between April 2021 and April 2022, staff across services for children and young people at the trust submitted 286 positive feedback incident reports which was an area utilised on the trust's incident reporting system to record feedback.

The service had learned lessons from a security breach in the CYPED and actioned the maintenance required to prevent reoccurrence.

Engagement

Leaders and staff actively and openly engaged with patients and those closest to them, staff and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had various mechanisms in place to gain feedback from children, young people and their families. We saw there was a feedback tree on the children's ward (ward 15) where people could leave compliments and suggested improvements. There were also varying surveys and media campaigns that were completed by the trust, including "feedback Friday" where the trust shared feedback from patients and their families on social media websites.

We saw that actions had been taken from the results of a parental survey on SCBU (Ward 23) to improve access to siblings on the ward and improve access for parents to consultants and decision makers. This was as a result of a targeted feedback survey.

The service used feedback from children, young people and their families was utilised to support service improvements. For example, pupils from a local secondary school had been invited to provide feedback during the design phase of the children and young person's emergency department (CYPED). Staff in the CYPED also told us that they had been involved in the design of the department to make sure it worked for the service and the patients they saw.

On the children's ward (ward 15), there was a feedback tree where children, young people, parents and carers were encouraged to give feedback. Changes from feedback given on the tree included ward rooms repainted with colours picked by children and young people, picture lights and sensory lights and improvements to the overnight accommodation and kitchen for parents.

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.

We saw examples of quality improvement initiatives in services for children and young people. This included work to standardise pathways and protocols across children's areas, combined paediatric patient safety, including patient safety meetings, simulations and huddles to improve communication and joint working when areas were not co-located, the development of bespoke training packages to meet staff needs and standardising patient records in the CYPED. The paediatric team had been awarded gold accreditation and the SCBU team had been awarded platinum accreditation for patient safety and quality from the trust.

Staff in services for children and young people contributed to research; we saw there were 10 active research areas, including areas like diabetes, epilepsy and autism, and the service were accepted to participate in a further six research studies.

Services for children and young people

The named safeguarding doctor and nurse for services for children and young people had done a significant amount of work to improve safeguarding processes, policies and procedures to make sure they were safe and effective. This included a designated child protection medical suite designed to improve the child and family experience, compliance with all national child protection service delivery standards (2020), including the development of an audit programme of the standards which were not yet available nationally, and the service completed five child protection medical audits in the last two years, where the results of three were presented at national and international conferences.

The service had allocated two slots per day for protected time to complete child protection medicals, developed and rolled out training for medical staff to take medical photography, and developed a feedback form for police and social workers for the assessments, so that the service could continue to develop and improve child protection medical services.

University Hospital of Hartlepool

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Description of this hospital

The University Hospital of Hartlepool is part of North Tees and Hartlepool NHS Foundation Trust. The hospital provides a range of diagnostic services, outpatient clinics, maternity services, day case and low risk surgery.

The trust provides integrated hospital and community-based services to approximately 400,000 people living in East Durham, Hartlepool, Stockton on Tees and surrounding areas including Sedgefield, Easington and Peterlee. It has a workforce of approximately 5500 staff.

The trust provides the following acute core services:

- Surgery
- Maternity and gynaecology
- Children and young people
- Outpatients and diagnostics

Maternity

Requires Improvement ↓

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.

Nursing and midwifery staff received and kept up to date with their mandatory training. The trust had a target compliance of 90%, at the end of March 2022 95% of midwives and 90% of clinical support staff had completed their mandatory training.

The mandatory training was comprehensive and met the needs of women and staff. The service had an education lead that monitored mandatory training, adapting sessions yearly based on incidents within the service.

The training lead and managers monitored mandatory training and alerted staff when they needed to update their training. Staff reported they were given protected time to complete their training.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. All medical and midwifery staff received level three children's safeguarding training. Compliance rates were 99% for qualified staff against a target of 100%. 100% of medical and qualified staff had completed level 2 safeguarding children.

100% of medical and qualified staff had completed adults safeguarding level 3 and 98% of medical and 94% of qualified staff had received level 2 safeguarding adults training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them, however we did not observe safeguarding information being shared during handovers.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to contact the lead midwife for safeguarding who provided support and supervision for staff.

The service had a baby abduction policy; we saw ward areas were secure, and doors were monitored. Due to the COVID-19 pandemic, the trust had not undertaken a simulation of a child abduction in the reporting period, however we saw this had been reported at board level, and there were plans in place to recommence scheduled simulations.

Cleanliness, infection control and hygiene

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

Areas were generally clean and had suitable furnishings which were clean and well-maintained.

Hand hygiene audits for the previous year demonstrated 100% compliance

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff in ward environments followed infection control principles including the use of personal protective equipment (PPE). Audit data for the previous year demonstrated the Rowan suite had good compliance with Covid-19 IPC audits which included access to PPE.

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

Environment and equipment

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

The site had an outpatients department with six consulting rooms, an antenatal day unit (ANDU) and the Rowan Suite. The Rowan Suite supported a continuity of care team of midwives and had two delivery rooms, a clinic room an active birth and pool room.

Women could reach call bells and staff responded quickly when called. Results from the 2022 CQC maternity survey showed the service performed the same as other trusts for staff being able to get a member of staff when needed.

The service had enough suitable equipment to help them safely care for women and babies and staff carried out daily safety checks of specialist equipment. Adult resuscitation trolleys were checked daily, baby resuscitations were available for babies.

Equipment servicing and electronic safety checks were monitored by the trust's estates team.

The pool room was equipped to get mother and baby out of the pool in an emergency.

There was no equipment in place to monitor and alert staff if someone tried to remove a child from the service but doors into and out of maternity areas were secure and monitored electronically.

The ANDU waiting area was not visible from the main reception desk and located next to a clinical area which did not promote privacy and dignity.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff used recognised to tools to monitor women and babies however compliance to these tools was not monitored. Not all areas of practice followed best practice guidance.

Staff used a nationally recognised tool to identify women and babies at risk of deterioration. Women were monitored using the modified obstetric early warning system (MOEWS) and staff told us there was process in place for escalation.

We observed evidence MEOWs had been completed accurately in women. Midwife staff were trained to take blood cultures preventing delays in starting treatment if a woman became unwell with sepsis. MEOWS audits for the period April 21 – April 22 showed overall compliance ranged from 80% to 99%, with five months above 95%. Action plans were in a place to address and improve compliance.

Babies were monitored using the Paediatric Early Warning Score, audits against the tool however from the information provided it was not clear to identify which area the audit had been carried out.

The Rowan team accepted transfers to the team up to 28 weeks of pregnancy. Only those women classed as low risk could be treated by the team and all woman were screened by specialist clinical midwives at booking. The service continually assessed women's risk throughout the pregnancy and transferred their care if needed.

We saw evidence of fetal monitoring during labour and a buddy system ('fresh eyes') was in place to review cardiotocograph (CTG) traces during continuous fetal monitoring. However, practice we observed did not follow the requirements for an hourly approach to fresh eyes and this wasn't reflected in policies, we did not see any evidence the service was updating its practice inline with requirements for frequency of monitoring, however the service did have a fetal monitoring lead and regular multidisciplinary CTG training was undertaken

Midwife staffing

The service had 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. However, the service had a rising vacancy rate.

The service had enough nursing and midwifery staff on the days of our visit to keep woman and babies safe, however the service had 13 whole time equivalent (WTE) midwife vacancies in May 2022 and vacancy rates were increasing. A nationally recognised assessment of the workforce was last completed in 2019 and the trust were planning to commence the required three yearly establishment review, in line with national requirements.

The Rowan team had 6 WTE midwives who covered the service 24hours a day seven days a week. At the time of the inspection the team where fully staffed. The birthing centre was staffed during the day 9am till 5pm and out of hours there was always two midwives on call. Staff in the team worked four days a week with two on call shifts. Midwives in the team had an average caseload of 35 women.

The ANDU had planned staffing for two midwives during opening hours, however we were told there was often occasions when only one midwife would be on duty. During these periods higher risk women were seen at the ANDU unit at the University Hospital of North Tees.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. The service had ten consultants with one vacancy at the time of the inspection. Consultants provided a minimum of 98 hours of cover each week, which met the Royal College of Obstetricians and Gynaecologists requirements for the number of births.

Medical staff were available to provide support over the phone daily and consultants were on site when undertaking clinics which routinely ran three times a week

Maternity

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.

Women's notes were comprehensive, and all staff could access them. The service used a combination of electronic and paper records.

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

The sharing of information on discharge was managed by the ward clerks who would send electronic referrals to GP and community midwifery teams.

Records were stored securely.

The service kept records of referrals to specialist centres, an audit undertaken for the period January -March 2022 highlighted 100% of records reviewed had evidence of the referrals made.

Medicines

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

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

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Midwifery staff in the Rowan team worked to patient group directions (PGD's). All midwifery PGD's were managed by one of the unit managers who had a system in place to ensure annual compliance. Records we reviewed showed all PGD's were in date and had been signed by those using them. New PGD's were not implemented until training compliance reached 80%.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents however learning from incidents was not widely shared.

Staff knew what incidents to report and how to report them, however we were not assured incidents were appropriately graded due to the high number of those categorised as low or no harm compared to incidents of moderate harm of above. For the period April 21 to March 22, 99% of all incidents were categorised as low or no harm. From the data we reviewed we identified incidents of post partum haemorrhages of over 1500mls categorised as no harm as well as incidents of women being transferred to intensive care classed as low or no harm.

The service held weekly MDT risk management meetings where any incidents that were to be closed were discussed. Staff told us most incidents were investigated at ward level. We reviewed minutes from these meetings and found that learning was not always identified, despite incidents being discussed.

Maternity

There were zero never events within obstetrics in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Managers reported relevant incidents to external organisations for investigation. Between May 2021 and August 2022, three incidents had been referred for external investigation to the Health and Safety Investigation Branch (HSIB). HSIB conducts independent investigations of patient safety concerns in NHS-funded care across England.

Perinatal deaths within the service were investigated using the Perinatal Mortality Review Tool (PMRT). The PRMT is a national programme aiming to standardise perinatal mortality reviews across NHS maternity services.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance, however some areas of practice had not been updated and evidence based practice was not always followed.

The service had an annual audit programme in place and took part in national and local audits. Local policies, procedures and clinical guidance were accessible on the trust intranet site. All maternity service policies and procedures we reviewed during our inspection were found to be up to date. However, we found the practice and policy for continuous electronic monitoring of fetal heart rates had not been updated in line with best practice guidance.

Fetal growth was monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by MBBRACE-UK (2015) and in line with current NICE Guideline (CG62).

The Saving Babies Lives Care bundle, Version 2 (SBLCBv2) is a series of measures introduced by NHS England in 2019 to help reduce perinatal mortality, element 2 requires risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction. The service was utilising the Perinatal Institute Growth Assesment Protocol (GAP) which included customised growth charts to meet this requirement.

The service had three midwifery sonographers who were community midwives could refer to if concerns were identified with fetal growth restriction.

The service undertook screening for gestational diabetes in line with national recommendations.

Nutrition and hydration

Staff ensured women had access to food and drink.

Staff made sure women had enough to eat and drink, they made adjustments for women's religious or cultural needs. The Rowan suite had facilities for partners to make a drink.

The continuity of carer service reported a positive impact of breast-feeding rates.

Maternity

The service had previously achieved full accreditation from the UNICEF baby friendly initiative. Reaccreditation was overdue however the service had started the initial stages of the process and submitted a certificate of intention. The programme accredits units for supporting breast feeding.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Nitrous Oxide and diamorphine were available as pain relief for woman cared for by the continuity of carer team.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

The service monitored the effectiveness of care and treatment, however information on outcomes was not always accessible to all staff.

The service participated in relevant national clinical audits and had an audit programme in place.

In the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) perinatal mortality surveillance report published in October 2021 (based on births in 2019), the stabilised and adjusted perinatal mortality rate at the trust was within 5% of the comparator group average for all births and those excluding congenital anomalies, this meant it was not significantly different to expected. The service had an improvement plan in place based on the outcomes of the report.

Better Births (2016), the report of the National Maternity Review, recommended a nationally agreed set of indicators should be developed to help local maternity systems track, benchmark and improve the quality of maternity services. A national series of Clinical Quality Improvement Metrics (CQIMs) were introduced.

For the period April 2021 to March 2022 the service had lower rates of post partum haemorrhages per 1000 women than the MBRRACE- UK average. For the same period the service had higher rates of 3 and 4th degree tears per 1000 women than the MBRRACE-UK average for eight out of the nine months data was available.

The Rowan team outcome data fed into a continuity of carer performance dashboard which was manged by the team lead. Since the unit opened the service reported improvements in breastfeeding rates and a reduction in episiotomy rates.

Competent staff

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Newly qualified midwives undertook a preceptorship programme and worked rotationally to develop their skills across all areas of midwifery.

Maternity

The trust had adopted the A-EQUIP (Advocating for Education and Quality Improvement) model of supervision and there were three Professional Midwifery Advocates (PMA) within the service and a further two being trained. Staff reported the PMA's were supportive.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates at the end of March 22 were 91% for midwives, and 100% for support staff. The trust had a target of 95% for appraisals.

The service had an education lead who supported staff to complete training relevant to their role. Regular MDT skills training sessions. Recent skills training sessions had included new-born resuscitation, pool evacuation, post-partum haemorrhage and cord prolapse.

Staff had received training and assessment on fetal heart rate monitoring through a maternity specific training programme (K2). Compliance rates for training were 98% for midwifery staff up to March 2022.

Antenatal and newborn screening updates were completed annually by staff, compliance rates were on average 91% up to March 2022.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff we spoke with said they had a good working relationship with the MDT. Midwives told us they were happy to raise concerns and challenge practice with medical staff where they felt this would help to keep women and babies safe.

Staff reviewed women's mental health and the service and was supported by the reflection's midwives. The reflections service offered a midwifery led debriefing service to help people talk through their birth experience.

The service had a community based perinatal mental health lead however they had no protected time for the role and they did not have a caseload for mental health. The service reported they were well supported by teams from the local mental health trust.

The service worked with neighbouring trusts to support women needing specialist care at a fetal medicine unit. Midwives worked alongside consultant leads, community midwives and specialists at regional centres to provide MDT care and care planning for women.

Seven-day services

Key services were available seven days a week to support timely care.

The ANDU was accessible for women five days a week. Women could contact triage at any time.

The Rowan team were available to support women 24-hours a day, seven days a week.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

The service provided guidance and encouragement to women on vaccinations including flu, pertussis and coronavirus and we saw evidence that Vitamin D was appropriately offered to some women. Some midwifes were trained to give vaccinations.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw evidence that carbon monoxide was monitored in women.

Staff from the Rowan team supported women to maintain a healthy pregnancy and had set up initiatives including group walks at a local beach.

Consent, Mental Capacity Act and Liberty Protection Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

All staff received training on the mental capacity act and liberty protection safeguards (formerly deprivation of liberty safeguards) as part of their safeguarding training.

All staff received annual consent training, the trust had a 95% target for compliance, all but one staff group within maternity were meeting this target with 100% of medical staff and 97% of midwives having completed the training.

Consent for screening was undertaken and sonographers would request this if not completed.

In the 2021 CQC maternity survey the service did better than expected for questions being asked around women's mental health.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were very attentive to patient needs, we saw positive feedback about the care women and their partners had experienced on social media pages. No patients were using the service at the time of our inspection.

The Rowan team offered the choice of birthing location to women to meet there needs. The staff would open the birthing suite if women wanted to birth there during periods it was closed.

The Rowan team had special clothing and accessories to offer to woman that showed they had care received from the team.

Maternity

Staff followed policy to keep women's care and treatment confidential.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. However, the service lacked specialist support or training. They understood women's personal, cultural and religious needs.

Staff supported and helped them maintain their privacy and dignity.

The service had two reflections midwives that were available to provide support for people to discuss the events surrounding their birth.

In the 2021 CQC maternity survey the service did better than expected for questions around mental health during pregnancy.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with women, families and carers in a way they could understand. The service did better than expected for being spoken to in a way they could understand in the 2021 CQC maternity survey.

The service ensured women had appropriate birth plans in place and encouraged partners to support.

For the period August 2021 to February 2022, the service received positive feedback from their friends and family survey, however this was lower than the trust target of 95%.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. We saw friends and family feedback boxes located within the ANDU.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service worked with others in the wider system and local organisations to plan care, however there was no active partnership group to develop the service and women who needed specialist care did not have access to dedicated specialist midwives.

Managers planned and organised services so they met the needs of the local population. The service had one continuity of carer team. Prior to the Covid-19 pandemic were plans were in place to increase this approach to midwifery care, in line with recent recommendations, these plans had been paused.

Maternity

Facilities and premises were appropriate for the services being delivered. The delivery unit had enough space and facilities to provide individualised care for women.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, this was provided by specialist teams from the local mental health trust.

The service did not have an active Maternity Voices Partnership (MVP). The MVP is an NHS working group and includes a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care based on local needs.

Managers ensured that women who did not attend appointments were contacted. Systems were in place to communicate with a woman and their community teams if they did not attend an appointment.

Partners could be present during a woman's time in the Rowan Suite.

Meeting people's individual needs

Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Managers made sure staff, women, loved ones and carers could get help from interpreters or when needed. We did not see any evidence of information available in other languages than English and staff told us it wasn't possible to get information in other formats.

Women were given a choice of food and drink to meet their cultural and religious preferences.

National guidance outlines that women should be provided with three choices of places to birth. The Rowan team allowed those within the area multiple choices for places to birth, including at home, the midwifery led unit or at a local consultant led service.

Separate rooms were available in outpatients for people who had received bad news. Guidance was in place for staff to support in working with bereaved parents and covered taking their baby home, postmortem, placental samples and histology. However, the service lacked specialist bereavement midwives or training.

We saw evidence that women were asked about domestic abuse. In outpatients staff had the opportunity to see women without their partners present to provide occasions for women to raise concerns.

All women were booked into the service were reviewed by two specialist clinical midwives. The specialist midwives worked alongside consultants and triaged each woman into low or high-risk categories. The specialist midwives also reviewed women who fell into certain high-risk categories including those with a raised body mass index, those that smoked, had diabetes or were experiencing multiple pregnancies.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Maternity

The Rowan suite was available for women who were being cared for by the continuity of carer Rowan team, the unit was open 9am to 5pm, Monday to Friday with midwives on call outside of these hours. 50 babies had been born at the unit since it opened in 2020.

Women within a designated aera who had a low risk pregnancy could chose to be cared for under the Rowan team, allowing them the opportunity to birth at the Rowan suite. If the unit was closed, midwives could open it up to allow women to birth there. Women stayed on the unit for an average of six hours.

The service had a maternity escalation processes which was integrated into local maternity systems. The process involved two stages with the first being internal escalation. For the period August 2021 to May 2022, the midwifery led Rowan team service had been closed once.

The ANDU offered appointments for women with referrals coming from GPs, community midwives and women themselves. The department used a RAG rated triage process for women which was based on risk.

There were three midwife sonographers, two scanned babies from 26 weeks, one had undertaken further training and was able to scan before this. The midwives helped improve flow through the department.

All women who contacted the service were triaged by midwives based at the University Hospital of Hartlepool Monday – Friday, 9am till 5pm, calls were triaged by North Tees ANDU and the labour ward after this.

The service had 18 clinics cancelled within six weeks of the appointment, for the period November 2021 to April 2022, four of these were at Hartlepool. The service did not monitor outpatient waiting times specific to the service. Process and policies were in place to monitor women who did not attend for an appointment.

For February 2022 19.8% of maternity patients did not attend their appointment against a standard of 13.2%, this was an increase from January 2022.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them.

Women, relatives and carers knew how to complain or raise concerns. There were posters in clinical areas which gave patients information on what to do if they had concerns about their care, including contact details for the patient experience team.

For the period May 2021 to May 2022 maternity services trust wide received 34 complaints, communication was the most complained about area with six of the 34 complaints. Staff and delays to treatment were also areas of concern with five and three complaints respectively. For the period May 2021 to May 2022 the service had received 68 compliments about the care and treatment received.

Managers investigated complaints and identified themes.

Is the service well-led?

Requires Improvement 

Maternity

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

Leadership

Leaders in post had the skills and abilities to run the service, however the service lacked senior midwifery leadership and clear structures.

The service was part of the Healthy Lives care group (care group 1). Information provided on leadership structures suggested the care group was led by a director with a clinical lead, head of nursing and care group manager.

Maternity services were led by a clinical director and an obstetric lead supported by a head of women's health and an operational manager.

Ward managers were in place to support the outpatients and Rowan teams. The service lacked a midwifery leadership structure above the ward managers. A senior midwife (employed on a consultancy basis) had been recruited to support the service following changes in senior midwifery leadership. They had been in post two weeks at the time of our inspection and were getting to know the service and teams. The head and deputy head of midwifery were not at work at the time of our inspection.

The service had an obstetric and board level safety champion and the champions met regularly. Due to changes within the senior leadership team, there was no midwifery champion in place. There was also no evidence ward level champions were in place. Senior leaders reported these had been hard to recruit to during the Covid-19 pandemic.

Vision and Strategy

The care group had a vision for what it wanted to achieve and a strategy to turn it into action, however maternity staff had not been engaged in the development. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service provided a vision and strategy as part of the Healthy Lives Care Group, which was part of the business plan for 2022-2025.

The vision described working with people in need of services, carers, communities, locality partners and staff to develop a system approach that continued to offer more innovative, community-based services, enhanced experience of services, improved population health, improved staff experience at work and provided services that were efficient, effective and value for money.

The care groups had outlined five priorities and intentions to work towards to enable them to fulfil their vision. These included areas such as utilising data and feedback, building a culture of respect encouraging innovation and making every contact count.

The trust provided evidence of a maternity vision and strategy, however, the vision was not locally developed and we saw no evidence staff were engaged with the care group vision.

Culture

Staff were focused on the needs of patients receiving care. The service had worked on improving the culture.

Staff reported the culture in the department had improved over the last six months however they shared concerns around plans for leadership of the service going forward. The delivery suite had worked on improving the relationship between medical and midwifery staff with a psychological safety programme within the department. A promoting positivity board was displayed in staff areas and the team where encouraged to share positive feedback.

The 2021 staff survey highlighted the service scored below the trust and care groups averages for several areas including a compassionate culture, leadership and inclusion. The ante/post-natal unit scored the lowest for the care group for recognition and reward and all areas within the service scored below the trust and care group averages.

For a health and safety climate, again the ante/ post-natal unit scored the lowest in the care group and both services scored below the trust and care group averages. Overall, the antenatal and post-natal unit scored lowest across the healthy lives care group and obstetrics (combined with gynaecology) was below the care group average and the sixth lowest out of 30 services. Senior leaders told us action plans to address concerns had yet to be developed. We saw board reports had identified further work needed to be done within ante/ post- natal areas.

Staff we spoke to told us they knew how to report incidents, we did not see any evidence learning from incidents was shared.

The service had recently been supported by the freedom to speak up guardian and recent cultural concerns had been addressed by changes in the senior team. Staff we spoke to were positive about their recent involvement and plans were in place for the guardian to be available to speak with additional staff during departmental meetings.

Governance

The service shared information with external organisations, however leaders did not always operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.

We found unclear processes of how ward to board assurances were gained about the quality and safety of services. A lack of effective and consistent midwifery senior leadership resulted in governance frameworks that weren't robust, and staff could not always articulate how information flows between the directorate and the board.

Monthly care group safety meetings were held where incidents, learning and risk were discussed, however information we reviewed highlighted there was not always maternity representation at these.

Seniors leaders we spoke to said information was shared to staff through ward managers. Ward managers told us team meetings were held but there was no set format or frequency for these. Data we reviewed showed each area had minutes for only one meeting in the last year and there was no record of any staff attendance. Daily ward meetings did not routinely cover safety or performance.

The service engaged with external organisations and reported any notifiable incidents to relevant bodies including the Health and Safety Investigation Brach (HSIB). Deaths within the service were investigated, where appropriate, using the perinatal mortality review tool, discussed at perinatal mortality review meetings and reported externally in line with national recommendations.

The service was meeting seven out of the ten requirements of the NHS Resolution Maternity Incentive Scheme at the time of submission. The Maternity Incentive Scheme (MIS) is an incentive for trusts to meet a set of actions that are

focused on improving the safety of services. Action plans were put in place to address the outstanding areas and at the time of the inspection the service reported they were compliant in an additional area. We saw evidence elements of the requirements had been reported as being met but these were not being implemented in practice, for example the use of hourly fresh eyes monitoring of fetal heart rate.

The service had an escalation processes which was integrated into local maternity systems. The process involved two stages with the first being internal escalation. For the period August 2021 to May 2022, the service had triggered the internal escalation policy 29 times. There had been no external escalation for the same period with no unit closures.

The Ockenden review was an independent review of maternity services that was carried out to identify areas for improvement across midwifery service. The final report was published in March 2022 and outlined 15 areas of immediate and essential action that expanded upon actions issued in earlier reports. The service reported they were partially compliant with 14 of the actions and fully compliant with one action.

Management of risk, issues and performance

Systems were in place to manage performance however these were not accessible to all staff or utilised effectively. Risks for the service were not always accurately recorded or updated.

Not all managers had insight into the availability of a local maternity system dashboard and although local dashboards were in place, these were not easily accessible to staff and we did not see this was used routinely to monitor performance.

Obstetric risks were recorded on a trust wide risk register however there was limited details of when risks had been reviewed. A risk had been identified in not meeting the national target for the continuity of care approach to maternity care by March 2022. Although the risk details had been updated since changes to the national guidance, it was unclear if the controls had also been updated in line with the national guidance updates as there was limited date information in the risk register.

Managers for the service reported different risks to those within the senior leadership team. For example, mangers identified a lack of infant feeding midwifes as a risk, this was not reflected on the risk register. The risk register had a risk identified for failing to achieve targets for breast feeding with controls being listed as ‘infant feeding midwives in post’.

Information Management

The service collected data and submitted notifications to external organisations as required, however there were gaps in data collected. All staff could not readily access data in accessible formats to help understand performance, make decisions and improvements.

The service had a mixture of paper and electronic records. Most of the records we reviewed were paper however some areas were mixed with paper and electronic records, including prescription charts.

The service submitted data to the Maternity Services Dataset to help in identifying areas that may require local clinical quality improvement

The service reported incidents to the national reporting and learning system (NRLS) and serious incidents to the strategic executive information system (StEIS). Qualifying incidents were reported to HSIB.

Maternity

The service presented performance information in several different formats, including a Maternal Perinatal Quality Surveillance report, Perinatal Quality Oversight Group high light report and a local performance dashboard. The service also had quality and safety dashboards which showed data including FFT response rates, hand hygiene, falls and pressure ulcers. Managers we spoke to reported performance dashboards were not easy to access and weren't routinely referred too and we saw no evidence the information was used to make improvements. Awareness of quality and safety dashboards was greater however displayed information was often out of date.

Engagement

The service recorded compliments received from patients. Plans were in place to restart engagement through the Maternity Voices Partnership.

Women could give feedback about the service directly; by raising concerns, complaints and compliments. They were also able to offer feedback through friends and family test (FFT) surveys and maternity services social media pages.

The FFT gives patients the opportunity to submit feedback on their care using a simple question which asks how likely they are to recommend the service to their friends and family. For the period August 2021 to February 2022, the service overall received positive feedback that was below the target of 95%.

The service did not have an MVP at the time of the inspection however plans were in place to recruit to vacant roles to restart the local group and engage with the community.

The service was part of the local maternity and neonatal system (LMNS).

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

The service encouraged staff to develop the service, the Elm team had been created to provide continuity of care for women undergoing a planned caesarean section. The team was created in response to the Covid-19 pandemic but had continued due to positive feedback from staff and women using the service.

The service had two research midwives and was taking part in several trials including

- COPE; the Carboprost or Oxytocin Postpartum haemorrhage Effectiveness study which was looking at the treatment of post delivery bleeding.
- The Parrot- 2 trial which was looked at repeat placental growth factor-based testing for women with suspected preterm pre-eclampsia.
- Big Baby Trial which looked at the Induction of labour for predicted macrosomia.