South Tees Hospitals NHS Foundation Trust

Friarage Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Friarage Hospital

Good 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Friarage Maternity Centre (FMC).

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

The FMC provides maternity services to the South Tees population.

The midwifery led unit at the Friarage included a birth centre and day assessment unit. Between 1 January 2023 and 30 June 2023, 51 babies were born at this service.

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

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

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

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

The James Cook University Hospital - Care Quality Commission (cqc.org.uk)

How we carried out the inspection

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

We visited the Friarage Maternity Centre (FMC), based within the Friarage Hospital in Northallerton, North Yorkshire. This is 1 of 2 acute hospitals forming South Tees Hospitals NHS Foundation Trust. FMC became a standalone midwifery-led unit in 2014 and was run by a team of midwives who provided care to women and birthing people with straightforward pregnancies. Women and birthing people were advised to transfer to James Cook University Hospital Obstetric- Led Unit when any complications occurred.

We spoke with the chief nurse, outpatient matron, 2 midwives and 1 maternity support worker. We were unable to speak with any women, birthing people or families. We did not receive any responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 6 care records of women and birthing people and 3 observation and escalation charts.

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

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

Maternity

Requires Improvement

We rated it as requires improvement because:

- The service did not always have enough midwifery staff, or they were frequently redeployed to James Cook University Hospital.
- Leaders did not operate effective governance systems. They did not consistently monitor the effectiveness of the service and did not always manage risk well. The unit was frequently closed for births, which made it difficult for staff to promote the service and women and birthing people, to plan to birth there.
- Leaders were aware the model of care at the Friarage Maternity Centre was not viable, but they had not been proactive in identifying solutions or promoting the unit.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect woman and birthing people from abuse, and managed safety well.
- The service managed infection risks well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- Staff assessed risks to woman and birthing people, acted on them and kept good care records.
- The service learned lessons from safety incidents.
- Leaders supported staff to develop their skills.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women, birthing people and the community, to plan and manage services.

Is the service safe?

Good

Mandatory training

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

The mandatory training was comprehensive and met the needs of women, birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. The Saving Babies Lives V2 quarterly data showed training compliances of 93% for Jan-March 2023 and 96% for April-June 2023 for fetal monitoring, human factors, situational awareness and successfully completed competency assessment on fetal monitoring.

Maternity

Midwifery and maternity assistants received and kept up-to-date with their mandatory training. Over 90% of midwifery and maternity assistants had completed all mandatory training courses against a trust target of 90%, although this was amalgamated as staff groups rather than locations. The only mandatory training that was below 90% was the newborn life support course, which all midwives needed to complete every 4 years. Compliance was 84.5% for midwives at the Friarage Maternity Centre (FMC) but 91.5% for annual newborn life support training across the trust.

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

The clinical educator was responsible for the planning, coordination, implementation and monitoring of the education and training programmes alongside specialist midwives, and other members of the multidisciplinary team. The out-patient manager for the FMC ensured staff completed the required maternity specific and trust mandatory training.

There were no medical staff based at the FMC but staff received multiprofessional simulated obstetric emergency training at James Cook University Hospital, and there was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people and babies.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training records showed staff had completed Level 3 safeguarding adults and safeguarding children training at the level for their role and as set out in the trust's policy and in the intercollegiate guidelines.

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

Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. They routinely asked women and birthing people about domestic abuse, female genital mutilation, and their mental health. These were mandatory fields in the electronic records. We reviewed 6 electronic records and saw these sections were completed in all. Women, birthing people and staff who experienced domestic abuse had access to an Independent Domestic Violence Advisor for expert advice and support, and this support was clearly advertised in the centre.

Maternity

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The electronic records had a facility which enabled staff to keep necessary documentation confidential. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. This included a lead practitioner who could provide support if a mental capacity assessment was required and a specialist nurse in learning disabilities.

The safeguarding lead midwife was based at James Cook University Hospital but attended FMC every 6 months to facilitate safeguarding supervision. Staff had access to the trust safeguarding team who also posted regular tips and updates on a closed Facebook group for maternity staff. The safeguarding team also shared a weekly safeguarding bulletin. This included national safeguarding reports, updated guidance, information, and reminders about details for safeguarding training.

Staff told us they used interpreting services for non-English speaking women and birthing people and information leaflets were available in the most used languages via QR codes.

Staff told us they completed baby abduction drills and we saw the unit was secure, and doors were monitored. They told us they had practised what would happen if a baby was abducted within the 12-months before inspection.

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

The safeguarding team submitted an annual safeguarding report to the trust board. This was also reviewed by the maternity safety champions. Learning and key messages were shared by a quarterly quality and safety bulletin. These included a brief synopsis of an incident, what was learnt, what the recommendations were, and what individuals should do to minimise the risk of recurrence.

Cleanliness, infection control and hygiene

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

All areas of the Friarage Maternity Centre (FMC) were visibly clean and had suitable furnishings which were clean and well-maintained. The FMC had recently been refurbished to the latest national standards. Flooring in the clinical areas and associated corridors allowed for effective cleaning. Curtains were visibly clean and disposable. The change date was recorded and there was a process to ensure a regular cleaning regime.

Domestic staff worked from 5am to 3pm and maintained cleanliness during this time. The duty midwife completed any deep cleaning (following a birth), between 3pm to 5am. Cleaning records were up to date and demonstrated all areas were cleaned regularly.

Staff cleaned equipment after contact with women and birthing people and it was clear equipment was clean and ready for use. Cleaning checklists for each room and equipment were up to date and clearly displayed.

Staff ensured the taps on the birthing pool were run twice a day. There was a standard operating procedure which provided clear guidance regarding the cleaning of the birthing pool and legionella checks, and the oversight of this was maintained by the estates team.

The service performed well for cleanliness. Staff followed infection control principles including the use of personal protective equipment (PPE) which was stored in wall mounted displays. Laminated hand washing posters demonstrating best practice in techniques were on display above sinks and we noted all staff had their arms bare below the elbow.

Leaders completed regular infection prevention and control audits for the FMC and results were above 99%. We saw the infection prevention and control team had completed over 30 hand hygiene audits in maternity for the 3 months prior to our inspection. Results ranged between 84%-98%, although these did not identify the different clinical areas, so it was not possible to know what results if any, related to the FMC.

There was clear information displayed regarding infection prevention and control measures. For example, safe management of equipment, linen, waste management and PPE.

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 design of the environment followed national guidance. The Friarage Maternity Centre (FMC) was fully secure with a monitored entry and exit system. A risk assessment of all ligature points had been completed in May 2023 and call bells were accessible to women and birthing people, if they needed support.

The FMC and all rooms were bright, spacious, well maintained and there was a calm and welcoming atmosphere. There were 3 clinical rooms which were all ensuite and had air conditioning. One room was used for antenatal appointments, 1 was for labour/birth and included a recently fitted fixed birthing pool, and the other room was for postnatal care, assessments, and breastfeeding support. There was a room used for training and in-situ simulations.

There was a reception area on entry and a back office for staff to complete administrative work and receive handovers in a confidential environment.

The service had suitable facilities to meet the needs of women and birthing people's families. Clinical rooms included sofa beds so birth partners could comfortably sleep and stay over to support women and birthing people.

The service had enough suitable equipment to help them to safely care for women, birthing people and babies. For example, there were pool evacuation nets in the pool room and a mobile inflatable pool was also available. Rooms included dimmable lighting, electric candles and music to promote a calm and tranquil feel. There was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment on the day assessment unit.

There was a storage room which was well organised and maintained. Stock was clearly labelled and accessible and we randomly checked 10 pieces of stock and noted they were all in date and stored in an orderly way to ensure easy access.

We randomly sampled electrical equipment and saw electrical safety testing was in date. We saw evidence the electrical equipment was routinely checked and recorded, and leaders maintained oversight of this. Eighty-two pieces of electrical equipment had been tested in the previous 12 months and 2 out of the 82 had failed and were not for use. All medical equipment had been recently checked and any required maintenance work had been completed.

Staff carried out daily safety checks. For example, records showed that resuscitation and emergency equipment had been checked twice daily (on every day and night shift).

We saw evidence of monthly fire safety checks which were up to date and safety compliant. Fire exits were clearly signed, free from obstruction and medical gases were stored safely and in date.

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

We noted the fridge temperature was recorded daily for the milk fridge used for safe storage of breast milk and formula. However, we saw the temperature was frequently outside the accepted range, and although the fridge was empty on these occasions staff had not acted to rectify this. There was a reminder for staff to refer to the standard operating procedure (SOP) for storage and refrigeration of human milk when temperature(s) were outside the expected range.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration and transferred their care to the James Cook University Hospital.

The Friarage Maternity Centre (FMC) was a standalone midwifery-led unit based in the Friarage Hospital in Northallerton. The unit was run by a team of midwives who provided care to women and birthing people with straightforward pregnancies.

Women and birthing people were continuously risk assessed by their community midwife in relation to suitability of birthplace. They were offered the FMC as a place for birth unless they developed complications in pregnancy. There was ongoing holistic assessment during labour and birth and staff told us they had a low threshold for transfer to James Cook University Hospital (JCUH), to maintain safety.

There was a contact board on display opposite the workstation with clear information for the correct person/service to contact in an emergency and for clinical and non-clinical support and advice. This included the contact details for managers and on-call medical staff. There were clear instructions of what details/code to share when requesting an ambulance in an emergency and a dedicated phone-line for staff to use in the event of an emergency transfer to JCUH. The ambulance service number was accessed via ‘speed dial’ on a designated phone and could also be ‘bleeped’ from the clinical rooms, if necessary.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by staff. Each episode of care was recorded by health professionals and was used to share information between care givers.

Maternity

During the inspection we attended the morning handover and although there was no care to hand over, key information was shared. For example, staff were reminded to read the updated controlled drugs policy, and tasks were handed over, which included updated bloods results which needed to be communicated to the relevant people and planned clinical work to help staff prepare.

Staff had 2 safety huddles every shift to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. However, we requested audit results for compliance to SBAR and did not receive any results. We could not be certain leaders were assured of the quality and consistency of clinical handovers.

We observed staff managing the advice-line. They used an aide memoir/algorithm that was embedded in the electronic system. This ensured key information was requested and recorded in a consistent, confidential and methodical way. We observed thorough risk assessments, appropriate advice, sign-posting and accurate and timely record keeping.

Women and birthing people could self-refer to the FMC at any stage of their pregnancy and they were risk assessed to determine their suitability. We were told women and birthing people were referred to an obstetric consultant or professional midwifery advocate if they chose to birth there outside of guidance and a personalised plan of care would be agreed between them.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers, which affected the ability to offer the unit as a reliable choice for labour and birth.

The team was 3.6 whole time equivalent midwives under establishment; these posts were being advertised when we inspected, and staff told us the team at the Friarage Maternity Centre (FMC) covered any unfilled shifts so staff were always familiar with the service.

Staffing levels did not always match the planned numbers which regularly meant the FMC had to close for births. This mostly happened because staff were redeployed to the James Cook University Hospital (JCUH) during periods of escalation. Staff shortages due to sickness at the FMC had also led to closures. This was very disruptive and unpredictable for women and birthing people who planned to labour/birth there and the team who chose to work there. Staff could be called to help at short notice and the acuity could be very different on arrival to JCUH as the journey time could take over an hour.

Staff also told us they had frank conversations with women and birthing people and advised them they could not guarantee a member of the team would be available to look after them in labour. This made it hard for staff to promote FMC and hard for women and birthing people to plan to birth there.

On the day of inspection midwifery staffing should have been 2 midwives plus 1 maternity assistant (MA). There was 1 midwife, I MA and the team leader. The community midwives provided on-call cover for any births at the FMC or home births. They supported as necessary for up to 4 to 6 hours at a time. Two midwives were required when someone was in established labour.

The staff also managed the advice-line and provided support outside of labour/intrapartum care. For example, ad hoc breastfeeding support, antenatal appointments and planned examination of the newborn checks. However, the FMC was completely closed on a regular basis.

Maternity

There was always a senior member of midwifery staff on duty who had oversight of staffing levels. They ensured any staffing related risks were mitigated appropriately.

Staffing issues and acuity fed into the safety meetings with JCUH twice daily. The team leader or nominated FMC midwife joined virtually. This ensured staff at JCUH had an overview of FMC and they could collaborate to support each other. We observed the morning safety meeting. Staffing, occupancy, planned admissions and workload for both sites were discussed. Issues were escalated in between meetings to the matron of the day, as and when needed.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A maternity 'red flag' event is a warning sign that something may be wrong with midwifery staffing. However, we could not determine if there were any red flags related to FMC as red flags were amalgamated with JCUH.

Managers made sure staff received any specialist training for their role. For example, all midwives working at the FMC had completed most of the mandatory training, had their competencies signed off, passed clinical assessments, and completed additional training such as the examination of the newborn course and newborn life supporter course.

The service made sure staff were competent for their roles. Managers held supervision meetings to provide support and development. Appraisal rates were provided to us, and were just below 82% for nursing and midwifery staff, against a target of 80%.

Records

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

Maternity services started its digital journey in May 2023. This included transitioning from a hybrid system of paper and digital with limited functionality, to fully functional electronic records. We saw electronic documentation was not always saving on the system, which had been added to the risk register on 4 July 2023. This sometimes caused loss of data, delays to care and poor staff experience.

Leaders had received multiple reports because documentation and entries were not saving on the recently implemented electronic records. At the time of our inspection staff at the Friarage Maternity Centre (FMC) were recording contemporaneous paper records and then entering the documentation electronically, in case the system did not save. This could cause delays in staff accessing records and added to staff pressure and stress, especially when staff advised women and birthing people to attend triage, as they managed the calls and were responsible for recording the details.

An action log for maternity areas was completed and updated whilst the new IT system was being set up. This linked to the risk register and was updated until it was removed in October 2023.

We reviewed 6 electronic care records and noted they were competed in full. Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely store and manage medicines.

Maternity

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked could only be accessed by authorised staff. Medicines were in-date and stored at the correct temperature. Medicines for use in an emergency were also stored securely, were in-date and included clear and easy-to-use instructions for their use.

Staff monitored and recorded the medicine fridge temperatures and we saw this had been maintained at the correct temperature.

Medicine prescriptions were electronic and although we did not review any prescription charts, we did note safety information regarding prescribing was included on the safety notice board. For example, staff were reminded that Tinzaparin (used to treat serious blood clots, usually in the legs) dosage should be calculated according to the most recent weight and not the weight recorded during the first booking appointment.

There was a medicine management safety board at the FMC which included tips for safe medicine management and confirmed what a medicine error was.

Maternity services provided medicine management training for staff and submitted their training compliance. We saw data was only submitted for staff who worked at the James Cook Hospital and did not include any for staff working at the FMC. Therefore, it was not known what the training figures were for FMC.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. They told us they always reported any transfers to James Cook University Hospital (JCUH), if they had to close the unit or were unable to accept someone in labour.

Managers reviewed incidents on a regular basis so they could identify potential actions immediately. The service had a 'learning from incidents' culture. Safety messages were shared from floor to board. All staff received safety messages and learning from incidents and complaints by email, safety messages on screensavers, staff closed Facebook groups, handovers and safety huddles. There was evidence changes had been made following learning from incidents and staff feedback. For example, staff gave feedback about initial challenges when their IT system was upgraded, and they were given an option of using a personal computer or iPad.

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

Is the service well-led?

Requires Improvement

Maternity

Leadership

Local leaders were visible and approachable in the service for women, birthing people and staff but executive leaders did not always understand and manage the priorities and issues the service faced.

The leadership structure was well-defined and included the head of midwifery (HoM), the deputy chief operating officer, the clinical director (CD) for maternity services and the CD for the neonatal unit. The outpatient matron had oversight of the Friarage Maternity Centre (FMC), along with a full-time team leader. There were obstetric leads for different specialities such as fetal medicine. There was no dedicated obstetric lead for the FMC but there was a consultant midwife who provided expert advice, clinical leadership and senior support to the unit. Staff told us the leadership team were supportive and available and women and birthing people requesting to birth outside of guidance were referred to their named obstetrician and matron for FMC.

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

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

Leaders at the FMC were well respected and described as approachable, and supportive. They completed daily assurance rounds, reviewed safety checks. They ensured there was enough stock, equipment, shifts were filled and uniform compliance.

The executive team and senior leadership team visited infrequently due to the distance and required travel time, although leaders from the main unit linked up daily during virtual meetings and safety huddles.

Leaders had a clear understanding of the challenges to the quality and sustainability of the FMC but had not been proactive in finding solutions. The unit became midwifery-led in 2014, but the number of births had declined. This was because the unit was often closed for births as staff were required to support James Cook University Hospital (JCUH) during periods of escalation. There were no firm plans to manage or improve the model of care which was not fit for purpose and leaders were not proactive in promoting the services on offer.

The trust had commissioned an external maternity staffing review in line with NICE guidance (2015) using an acuity tool and professional judgement in 2022. We saw that 1 of the recommendations was to remodel community midwifery and the FMC, but nothing substantive had followed.

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

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

Maternity

Vision and Strategy

The service had a draft vision for what it wanted to achieve and a draft strategy to turn it into action, developed with all relevant stakeholders . The draft vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Maternity services had a draft vision for what it wanted to achieve and a draft strategy to turn it into action, developed with relevant stakeholders. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and had revised the draft vision and strategy to include these recommendations.

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

The strategy was dated 2023 to 2027 and provided a comprehensive 5-year improvement plan setting out aims, objectives, and benchmarks to monitor progress. We were told the consultation with MVP was due to conclude in December, with a view to publishing in January 2024.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

It was not clear if the service had a specific strategy in place at the time of inspection although staff at the FMC could explain their vision and what it meant for women, birthing people and babies. We saw the unit had their vision recorded in the information booklets for women, birthing people and families. The vision was recorded as ‘to provide excellent and evidence based holistic person-centred care throughout pregnancy, birth and the postnatal period. Working in partnership with birthing people to ensure their requirements were met with kindness, compassion, respect and understanding.’

Culture

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

All staff we met during our visit were welcoming, friendly and helpful. Staff were passionate about working at the Friarage Maternity Centre (FMC), supporting choice and normality. Staff described the team as ‘amazing’ and felt able to speak to leaders about difficult issues and when things went wrong. There was an emphasis on close working which included community midwives providing on-call cover for intrapartum care.

The FMC team described an appreciation and understanding of differences between their model of care and that of James Cook University Hospital who they supported with planned work. For example, for jaundice screening, examination of the newborn checks and breastfeeding support.

Maternity

Staff were focused on the needs of women and birthing people receiving care and promoted a culture that placed peoples' care at the heart of the service. Dignity and respect were intrinsic elements of the culture. We heard staff giving support and help over the advice-line and the way staff spoke clearly demonstrated this.

There were privacy curtains around clinical beds, couches and the pool, and visible alerts to remind staff to 'STOP/ THINK/ask before entering' and staff made it clear that women and birthing people could request a chaperone for examinations and appointments.

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

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

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

The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear. There were 3 Freedom to Speak up Guardians at the trust which included a midwife from JCUH. Maternity services had won a recent trust award for the service that had shown the most improvement in staff speaking up.

We saw and heard how staff wellbeing was supported at the FMC. There was a board dedicated to promoting wellbeing resources such as Apps, details of how to self-refer for counselling and useful information to promote/maintain a healthy lifestyle.

There had not been any recent complaints related to FMC, but the service clearly displayed information about how to raise a concern in areas used by women, birthing people and visitors. Staff understood the policy on complaints, how to handle them and the importance of learning from any complaints at the main hospital as well as FMC.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

There was a Clinical Effectiveness and Education group (CEEG) for maternity services, which monitored current risks and challenges, guidelines, audits and progress of various ongoing workstreams. There was a live action log for the CEEG meetings to monitor and track progress and performance. However, this was not always effective. For example, in June 2023 the meeting noted poor compliance with Gap and Grow training for midwifery staff (15%) and there was no discussion or action plan to improve this.

The CEEG did not have an effective process to monitor policies and review dates. All policies were required to be reviewed every 3 years to ensure they were up to date. However, some guidelines had passed their review date which

meant they might not reflect best practice and the waterbirth guideline did not include the process to follow if an evacuation was needed in an emergency. We raised concerns about this immediately on the first day of our visit to James Cook University Hospital (JCUH). This was quickly updated and shared with staff at the Friarage Maternity Centre (FMC), but it was difficult to understand how this had not previously been noted.

The laminated checklist staff used as a guide to determine suitability for birthing at FMC was out of date. The criteria still included low-risk inductions of labour, but we were told this was part of their exclusion criteria following a serious incident in 2022.

We reviewed the policy for midwifery-led care and noted the inclusion criteria included a body mass index of 40 and under, which is not low-risk. We highlighted this to staff who told us it was due to be reviewed but leaders had not assured themselves they had oversight of policies and procedures.

Managers and leaders shared their most recent audit of transfers from the FMC to JCUH. This included data from November 22 to September 23, and transfer data was presented as number values due to small denominators. Leaders told us there was a full clinical review of reasons for transfer and outcomes, and all transfers in this cohort were appropriate and there were no adverse outcomes. The audit identified where there were actions to be shared with staff and at which relevant committee meetings. We saw an example of action taken to review information available on birth choices.

There was no audit of transfer times or outcomes such as length of labour, analgesia used, perineal tears, blood loss and birth weight. In addition, although some information was captured, a review of meeting minutes did not provide any indication as to how this information was used to monitor the transfers by the local ambulance service or to develop and maintain the FMC as a place to birth rather than to operate as a hub.

Staff told us they discussed potential transfer times and reasons for transfers at the antenatal appointment at 36 weeks. However, there was no audit of these conversations and there was no information on the trust website regarding transfer times or to confirm the FMC could be closed for births. The service could not be assured women and birthing people had received the information to make an informed decision about birthing at FMC.

Equally, the policy for birthing at the FMC stated that women and birthing people should be referred to the FMC by default if they were low-risk when they called the advice-line in labour. This meant they would not have had the benefit of detailed discussions about the risks and benefits of birthing at the unit and preparing psychologically. However, as part of the factual accuracy process the trust provided evidence that they had updated this guideline in response to our concern.

The advice-line generated a significant volume of work which was managed by the FMC midwives. For example, there were 1549 in June 2023 and although leaders monitored the number of calls, there was no audit to determine the number of occasions the calls diverted to JCUH or the impact. Leaders did not audit if callers were given suitable advice, attended in a timely manner, how non-attenders were managed or how the inability of the FMC team to book appointments for non-urgent attenders impacted flow and activity.

Maternity safety champions met approximately every 2 months and there were several standing agenda items for discussion, such as key performance indicators, recruitment and retention, the maternity incentive scheme, and escalation. Meeting minutes showed effective learning from events which happened both internally and externally to

the service but did not record mitigations or actions which required follow-up or progress updates, which could indicate slow or ineffective governance processes. However, we were told the maternity safety champions meeting was part of the assurance process up to the board. Any actions and follow up was detailed in the Maternity, Safety and Quality Committee, with escalation as needed and minutes of meetings reflected this.

Maternity services had achieved all 10 standards for the maternity incentive scheme and external auditors also confirmed they were meeting the required standards.

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

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

All maternity specific mandatory training was recorded on local databases according to staff groups. The data base was updated and monitored by the clinical educator monthly. The Maternity Service Patient Safety Group, Trust Patient Safety Subgroup, and the Quality Assurance Committee (which was a representative of the trust board) monitored training compliance quarterly.

Quality Improvements, good news stories, and learning was shared from reviews through governance boards, closed Facebook groups for staff and emails.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They generally identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was a risk register for the trust and 1 for maternity services covering both locations, although there was the ability to select the location for a specific risk. Actions were assigned to all risks on the maternity and trust register, with the aim of reducing the risk. A risk was recorded for shortage of midwives and support staff impacting on service provision, quality of care, staff and user experience on the maternity risk register. Leaders had commissioned a review of the staffing establishment using a nationally recognised acuity tool, which was due to be completed by 30 September 2023. Leaders also engaged with staff and looked for solutions to risks. Opportunities were given to staff to express their opinion and ideas and the responses were captured from this exercise.

Culture had been added to the maternity risk register and this was considered a factor in staff retention, and an action plan was in progress to address this. Tensions existed because staff were frequently deployed to JCUH during periods of escalation. Midwives managed the advice-line but had no facility to book appointments for non-urgent appointments to support flow and help ensure women and birthing people were seen according to clinical need and urgency.

The advice-line was also diverted from FMC to the triage unit at JCUH if there was someone in labour/giving birth. This happened about 2-4 times per week and meant midwives at JCUH triage were expected to manage the telephone triage and assess people attending triage, which contributed to delays and clearly showed the process was not effective and impacted safety. This was an unknown risk that was not mitigated when we visited although the trust made some changes following the concerns we raised on the day and followed up with a Letter of Concern.

Matrons from FMC and JCUH had combined meetings and told us these issues were reviewed but we did not hear or see evidence of how leaders had engaged frontline staff to find solutions and mitigate the risks.

There were no records of women and birthing people booked to birth at the FMC so leaders could not be assured they had oversight of potential acuity and risk and plan accordingly.

Risks were identified through the incident management system and reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. For example, following a serious incident it was identified that emergency buzzers were not audible to staff in 1 area of FMC, and this potentially contributed to an adverse outcome. The investigation was still in progress when we visited and although emergency buzzers were immediately fixed, it was not clear why this had not previously been identified and managed.

Information Management

The service collected reliable data and analysed it but most data was amalgamated with the main hospital. Data or notifications were consistently submitted to external organisations as required.

Maternity services had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison. The number of births and transfers for Friarage Maternity Centre (FMC) and community activity were separated. However other data was amalgamated for James Cook University Hospital (JCUH) and FMC, even when they identified areas that required improvement. Managers did not have complete oversight, were not always able to identify issues and monitor improvements specific to the unit.

We could not see how data for women and birthing people who received care was collected, monitored and scrutinised. This included birth outcomes and breastfeeding support provided as an add-on service for mothers who had not birthed there. This made it difficult for leaders to identify risk and drive improvements.

Data or notifications were consistently submitted to external organisations as required. This included the National Neonatal Audit Programme, MBRRACE-UK and Maternity and Newborn Safety Investigations Special Health Authority. They had also completed the national perinatal review tool since the launch. This helped to ensure consistency of reporting nationally.

Managers told us community midwives collected data to identify higher risk women and birthing people at all booking appointments. This included ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index (BMI), advanced maternal age and co-morbidities. This was used to plan individual care needs and determine suitability to birth at the centre, although we noted high BMI was not part of the exclusion criteria.

Engagement

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

Maternity

The service had a well-established and valued Maternity Voices Partnership (MVP). The MVP was multidisciplinary. Meetings were rotated between the James Cook University Hospital (JCUH) and the Friarage Maternity Centre(FMC). They listened to feedback from women and birthing people who had birthed and been transferred from FMC. The MVP helped to ensure their voices were heard by the trust and used to make meaningful improvements.

Leaders and the MVP scrutinised user experience surveys and produced action plans to make improvements. Information evenings had recommenced, and video tours were being produced which were to be made available in the 5 most common languages spoken.

The MVP were proactive in ensuring leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups, in their local population. They worked hard to listen to communities who had previously been less heard. For example, they identified pregnant Nigerian women who entered the UK could be difficult to reach and engage in maternity services. The MVP worked in partnership with maternity services and Nigerian students at Teesside University to understand what the barriers could be and how to tackle them. Although Nigerian women and birthing people generally presented to JCUH, this work demonstrated a commitment to reduce health inequalities.

The service monitored results of the NHS staff survey, and there was an action plan to improve responses from the 2022 survey. Results for maternity and gynaecology were collated and compared with results from the organisation as a whole. The service had identified areas where scores had declined from the previous year and made suggestions to tackle this. Improvements and solutions were highlighted and monitored in a dedicated action-plan. For example, improvements in human resource processes, flexible working and retirement options, car parking provision for staff, culture and psychological safety training sessions and band 7 leadership development.

There were systems to engage with people who used the service. Staff proactively encouraged women, birthing people and families to give feedback, and made it easy for them to do so. They advertised a Facebook page for FMC and encouraged people to leave reviews and upload photographs of their time there. There were details of 'You said/we did' to summarise how leaders responded to user-feedback.

The governance team had introduced a QR code to make it easier for staff to share ideas for improvement and any concerns. There were staff information boards in the centre. This included details of how to contact the maternity safety champions, the Freedom to Speak up Guardians and where staff could get support.

There was an information board on entry which highlighted monthly statistics for the FMC and included the number of births, waterbirths, transfers, positive feedback about staff and a positive birth story written by a mother. There was another notice board which highlighted the details of staff, details of leaders and how to contact them, the midwife in charge for the shift and a staff uniform guide.

Information folders were available in every room and included details of the unit philosophy and services. However, the maternity website included very little information about the FMC. There was no visual information such as pictures or videos to show the environment and there was no information to confirm inclusion criteria, process for booking, transfers, journey times, statistics or feedback from service-users. It was difficult to understand why they were not actively promoting the FMC as they were concerned about the decline in activity and the viability of the unit, although during the factual accuracy process the trust advised they had updated it.

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

Maternity

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

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

Outstanding practice

No outstanding practice

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure there is a process to ensure oversight and management of policies, guidance and procedures to ensure they are reviewed in a timely manner, are clear and reflect national guidance (Regulation 17(1)(2)(a))
- The service must ensure they have regular audit to demonstrate compliance with standards and procedures, to identify gaps, implement and monitor improvement (Regulation 17(1)(2)(a)(b)).

Action the trust SHOULD take to improve:

- The service should consider the need for a separate risk register for the Friarage Maternity Centre
- The service should consider separating data collection from the James Cook University Hospital and use this to drive improvements.
- The service should consider how they can raise the profile of the Friage Maternity Centre.
- The service should consider how they improve the model of care to ensure it is fit for purpose.

Our inspection team

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