Chesterfield Royal Hospital NHS Foundation Trust

Chesterfield Royal Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Chesterfield Royal Hospital

Requires Improvement 

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 Chesterfield Royal Hospital.

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

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

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

The maternity department at Chesterfield Royal Hospital comprises of the Birth Centre with consultant led and midwife led beds, a combined antenatal and postnatal ward, a bereavement suite, pregnancy assessment centre, antenatal clinic and scanning services.

We did not review the rating of the location therefore our rating of this hospital stayed the same

Chesterfield Royal Hospital is rated Requires Improvement overall.

Our reports are here: https://www.cqc.org.uk/location/RFSDA

How we carried out the inspection

During our inspection of maternity services at Chesterfield Royal Hospital NHS Foundation Trust we spoke with 30 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the antenatal clinic, pregnancy assessment unit, the birth centre and the ante and postnatal ward. We reviewed the environment, maternity policies while on site as well as reviewing 9 maternity records. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received feedback from over 230 women and birthing people in response to the campaign. Comments were generally positive about the birthing experience, but less so about care on the postnatal ward. Women and birthing people commented that staff did not always have the time to provide support, especially with breastfeeding whilst on the ward.

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

Maternity

Good → ←

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

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Changes to the leadership structure had resulted in the governance structures within the service being strengthened.
- Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Despite staffing in excess of the national guidance across the unit, staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Is the service safe?

Good → ←

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

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with all their mandatory training.

Staff were not up-to-date with their mandatory training. The service had undertaken a training needs analysis, to provide a systematic approach to training of staff groups responsible for caring for women, birthing people, babies, and their families, through a multi-disciplinary approach. Following this, the service had introduced a 'learning week' for maternity staff, taking into account both national and local training requirements. Training included cardiotocograph (CTG) competency, skills and drills training and neo-natal life support. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. The delivery of the 'learning week' commenced in January 2023 and was delivered off-site every month. Staff commented positively about the format of the learning week, and the benefits to completing the majority of their training at the same time. Staff were also provided with additional learning time to complete trust specific training, the majority of which was provided through online training.

Maternity

The service acknowledged that their training compliance levels were currently below the required level of compliance but would improve with the introduction of the learning week. The service aimed for 90% compliance across all training but recognised that when taking into account sick and maternity leave, 85% compliance with essential training (days 1 and 2 of the learning week) for specific staff groups was realistic. The service planned to achieve this through delivery of the 'learning week' by the end of 2023. The current compliance rates for PROMPT training ranged from 67% for obstetric anaesthetic staff grade doctors through to 100% for general anaesthetic consultants, Tier 3 obstetric trainees and Tier 2 specialist obstetric trainees. Compliance for midwives was currently 69%.

The service provided additional training information following the inspection. This demonstrated that systems and processes were in place to monitor training compliance and report to both the Maternity Governance meeting and Safety Champions meeting to provide oversight and assurance. The service had taken action to mitigate against external factors affecting attendance at training and planned two additional PROMPT training days for October and November 2023.

The interprofessional clinical education lead acknowledged that the oversight of compliance with trust mandatory training needed to be strengthened. Since January 2023 the education team has been monitoring compliance for both maternity and obstetric staff and provided written training schedules for individual members of staff, so they are aware when training was due. Information was also provided to line managers prior to staff appraisals.

It was also acknowledged that emergency evacuation from a birthing pool needed to be revisited. We were told that nets were used for pool evacuations and there was a video for staff on how to carry out a pool evacuation. We did not see any training records relating to this. It was not clear if pool evacuation was covered in the trust mandatory moving and handling training, or if any training specific to maternity was covered.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all staff had completed it.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. The trust had developed three 'Think Family' workbooks plus an assessment that midwives and obstetricians completed on an annual basis. This training had been incorporated into the 'Learning week'. Eighty percent of midwives and 43% of obstetric consultants had completed Level 3 safeguarding adults and safeguarding children training. The service provided additional training information following the inspection. This showed that 84% of midwives and 54% of obstetric consultants had now completed Level 3 safeguarding adults and safeguarding children training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act 2000. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team. The safeguarding team received police protection notices for domestic abuse where there was a pregnant person or miscarriage.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures. We saw that staff made reference to safeguarding concerns during handover in a professional and dignified way.

Staff reported the service had seen an increase in concealed pregnancies during 2022, which had all been referred to the safeguarding team. The safeguarding team identified 7 concealed pregnancies in a 6 month period. A review of the records did not identify any themes or trends for these women. The safeguarding team also accessed the Child Protection - Information Sharing Service (CPIS) for women outside of area. This service provided a network across the country of women or their babies who could be at risk.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

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

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness. We saw audits were completed on a regular basis. The most recent audit was completed on 9 May 2023: the birth centre scored 91% and Trinity ward scored 80%. Issue frequently identified included damage to the environment which prevented effective cleaning and the accumulation of dust. The audits identified who was responsible for taking action to address to rectify the issues, although it was not clear if the required action had been taken.

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

Staff cleaned equipment after contact with women and birthing people. We saw cleaning stickers were used to indicate that equipment had been cleaned and was ready to use.

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.

Maternity

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

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. However, the service acknowledged challenges within some areas of the maternity unit. There was no direct observation of women and birthing people waiting to be seen in the antenatal clinic / pregnancy assessment centre, or a dedicated space for staff to discuss sensitive issues with women, birthing people and families. The service was considering how this area could be reconfigured to address these issues. We observed that it was difficult to maintain confidentiality during handover on the Birth Centre due to the layout of the area used, resulting in interruptions by staff accessing the area and the potential for discussions to be overheard.

Processes were in place for staff to carry out daily safety checks of specialist equipment. However, there were gaps in the daily checks of the emergency trolley on the Birth Centre. In addition, we found out of date personal protective equipment on the emergency trolley on Trinity ward. This was raised with the staff at the time and rectified immediately.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there were pool evacuation nets in rooms with pools and on the pregnancy assessment centre there were cardiotocograph machines and observation monitoring equipment.

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

Assessing and responding to risk

Staff 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.

The service had identified that a systematic approach for the triage of women and birthing people was not in place, and consequently triage had been included on the risk register. The service did not have a dedicated triage area, and staff did not have a Standard Operating Procedure to follow to provide consistency of approach. The service had a pregnancy assessment centre (PAC) located within the antenatal clinic area, which was open between 8.30am and 8.30pm. Women attended the unit via booked appointments for routine checks, such as blood pressure monitoring and blood tests. The triage service was also offered from PAC when open and women were advised to telephone for advice if they had any concerns. The telephone calls transferred to the Birth Centre from 7.30pm and women and birthing people were seen in the assessment room on the Birth Centre overnight. Staff completed risk assessments for women and birthing people on arrival and recorded the information in the electronic patient record. An additional midwife was planned to cover triage at night on the Birth Centre, making the numbers 10 in the day and 11 at night. However, it was not always achieved.

The service had reviewed incidents and triage had not been identified as a theme, although some issues were identified. As well as inclusion on the risk register, triage had been placed on the maternity improvement plan and the long term goal was to introduce a nationally recognised evidence based triage system.

Maternity

Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 9 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. The MEOWS audit was completed monthly to check they were fully completed. Audits between September 2022 and April 2023 showed 100% compliance and the up to date figure for May 2023 was 74%. The long term average was 96%.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used during pregnancy to monitor fetal heart rate and uterine contractions. The service told us CTG training was included in the learning week and all staff were required to complete a competency test before they were recorded as passing the training. The service had access to centralised CTG monitoring system at the midwives station on the Birth Centre to support oversight for the coordinators and medical staff. In addition to this 'fresh eyes' were completed by midwives to maintain an objective overview of any CTG readings. A recent audit of CTGs showed clear interpretation and management plans following CTG in 100% of cases. There was an expectation that staff used a 'fresh eyes' or buddy approach for regular review of CTGs during labour. The recent audit highlighted that 'fresh eyes' had only been completed hourly in 20% of cases. An action plan had been developed following this audit and included changes to the electronic patient record system to make hourly fresh eyes mandatory, development of a Standard Operating Procedure for fresh eyes, and sharing of information via the weekly newsletter and CTG club.

This shows the service is reactive to concerns and ongoing action is developed when required to make improvements.

Staff in theatres used the World Health Organisation (WHO) Surgical Safety Checklist which was a tool aimed at decreasing errors and adverse events in theatres and to improve communication and teamwork. We observed the completion of the WHO surgical safety checklist in theatre and found it to be completed correctly. The service had completed an audit of the WHO checklist in February 2023, and identified a number of areas that required improvement, the majority of which were around clinicians printing and signing their names to confirm checks had been completed. An action plan had been developed following this audit.

These show the service was reactive to concerns and ongoing action was developed when required to make improvements.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring at the point of booking. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during pregnancy. Staff screened women for depression using the 'Whooley questions.' The questions are a screening tool which was designed to try and identify symptoms that may be present in depression. There was a referral process to ensure support was accessible for women who identified with possible mental health needs.

We observed the handovers in each of the wards. The details shared included all necessary key information to keep women and babies safe. We observed that the midwifery staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. The medical handovers did not use the SBAR format to its full capacity.

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

Midwifery Staffing

Maternity

The service did not always have enough maternity staff. Staff had the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in March 2021. The service recognised that activity and complexity of women and birthing people attending the unit had increased since the last review. As a consequence, the service had commissioned an updated staffing and acuity review, which was due to report in June 2023. We saw that the service's number of contracted whole time equivalent (WTE) across maternity services in March 2023 (153 WTE) exceeded the number identified as required in the previous staffing review (127 WTE). Although the service had increased the staffing levels across the unit, the planned staffing levels were not always provided. We saw from the monthly Birth Rate Plus Acuity reports that shortfalls were usually due to short term sickness and being unable to fulfil vacant shifts. Staff spoken with told us that there were occasions when they were short staffed, although this had improved in recent months.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. The service completed monthly Birth Rate Plus Acuity reports. There had been 100 red flag incidents between November 2022 and April 2023. The impact of shortfalls in staffing were seen in areas such as delays in induction of labour (18), use of community staff in the hospital setting (28) and occasions when the co-ordinator wasn't supernumerary (26).

The service had a vacancy rate of 4.8% for midwives, the equivalent of 6 WTE. A number of midwives (4 WTE) were due to return to work over the next few months following maternity leave. The service mainly used bank staff who were familiar with the service to cover staffing shortfalls whenever possible. Sickness rates in March 2023 were 7.71% full time equivalent (FTE) for midwifery staff and 2.19% (FTE) for medical staff.

We saw the latest bi-annual Safe Nurse / Midwifery Staffing Establishment Review paper presented to the Board in November 2022. The paper highlighted areas that needed to be addressed and any mitigating actions that had been taken, for example increasing the number of supernumerary co-ordinators to two on each shift for nights and weekends and protecting Professional Midwife Advocate time to enable them to fulfil the role.

There was a supernumerary shift co-ordinator on duty who had oversight of the staffing, acuity, and capacity across the maternity service. Managers moved staff according to the number of women and birthing people in clinical areas and staff told us they were more likely to be moved to the birth centre than to the ward. The service also utilised community midwives to work in the hospital to cover staffing shortfalls.

Staffing across the maternity unit and community was discussed on a daily basis. This meeting included looking at planned activity on the day as well as for the next seven days. This enabled the service to proactively manage any staffing shortfalls in line with planned activity.

Staff told us about two activities that had the potential to impact negatively on staffing and work load. These were the overnight stays of patients on the women's health unit and covering triage calls overnight when the Pregnancy Assessment Unit was closed.

Maternity

We asked the service for additional information regarding the number of patients who required an overnight stay on the women's health unit. During the 12 month period of May 2022 to April 2023 167 women had required an overnight stay. Their care transferred over to staff on Trinity Ward from 10pm until 7am. The service told us that midwives had the skills and knowledge to care for patients on the women's health unit. The service recognised caring for these additional women had an impact on meeting the needs to the women, birthing people and babies on Trinity ward, and told us this needed to be reviewed and a more suitable arrangement found.

The triage service had been identified as a risk and included on the service risk register. The service were planning to introduce to dedicated triage service using a recognised assessment tool in the future. Staff told us additional staffing was not always provided on the Birth Centre overnight to cover the telephone calls and assessing women who attended for a review, impacting on their ability to care for women and birthing people on the unit. Leaders told us there was a planned extra member of staff to support this activity, however it was not always possible to achieve with the actual staffing numbers. The service was looking to increase the number of supernumerary co-ordinators on shift to cover telephone calls and assessing women and birthing people attending the unit for assessment overnight.

The service had a range of specialist midwives to support different areas. We spoke with the birth trauma specialist / bereavement midwife who shared with us the support networks on offer for women and families who have lost a baby. They said they had started to work closely with the maternal mental health and perinatal mental health midwives to create a team approach to supporting women and birthing people through trauma and loss.

The service had maintained their Continuity of Carer (CoC) Team. Women and birthing people were cared for by the same midwife throughout their pregnancy and supported through labour and delivery whenever possible, including in the hospital setting.

The service was proactively looking at managing potential staffing shortfalls over the summer months. Staff told us that they had been asked if they were able to work extra hours during the period, as well as specialist midwives being rostered to work clinical shifts within the maternity unit.

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.

There were systems and processes for managers to support staff to develop through appraisals, with appraisals taking place between April and July each year for non-medical staff. Completed appraisals data for 2022 indicated 71% of non-clinical midwifery staff and 76% of clinical midwifery staff had received an appraisal.

The service had recently strengthened the Maternity Support, Education and Training (SET) team. This team provided support for midwifery and medical staff, and included clinical educators, the preceptorship team, professional maternity advocates, student midwife support as well as the maternity support worker transformation midwife and the fetal monitoring specialist midwives. The clinical educators with support from the fetal monitoring midwives had been instrumental in the development of the multidisciplinary learning week.

Maternity staff were supported by a team of 8 Professional Maternity Advocates (PMA). The PMAs supported staff with debriefs immediately after incidents and in the longer term, following any investigations. Band 5 preceptorship midwives were supported by the maternity SET team, in particular by the three preceptor midwives. The preceptorship midwives were provided with a structured programme to work through over an 18 month period. The Preceptorship Lead Midwives worked alongside the newly qualified midwives in the clinical setting, as well as providing structured teaching sessions off site.

The fetal monitoring lead midwife organised a cardiotocograph (CTG) club twice a week. This was open to all staff who wished to attend, to consolidate learning around CTGs and to discuss any interesting cases.

Medical staffing

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

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff.

The service had 15 consultants in post, with one vacancy for a consultant in fetal medicine. This had been included on the service's risk register. The post had been advertised but interviews had not taken place. The service had a vacancy rate of 9.3% for middle grade medical staff. The service told us they were working with the local medical deanery to try and resolve this issue. The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. Sickness rates in March 2023 were 2.19% (FTE) for medical staff.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Midwifery staff told us that some of the newer consultants chose to remain on site when they were on call overnight.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff attended training as part of the 'maternity learning week' to support multiple disciplinary team training and to develop good working relationships.

Records

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

Women and birthing people's notes were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. The majority of information was recorded electronically although paper records were used for medicine charts. We reviewed 9 electronic patient records and found records were clear and complete.

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

Records were stored securely. Staff locked computers when not in use.

The service had undertaken a retrospective audit of both electronic and paper patient records. The findings were presented to the Clinical Audit Meeting on 19 May 2023. The audit demonstrated an improvement in record keeping when compared to the previous audit in 2021. A further audit was planned for late 2023 to monitor that the improvements had become embedded.

Medicines

Maternity

The service used systems and processes to safely prescribe, administer, record and store medicines although these were not always used effectively.

The service had systems in place to check staff competency when using medicines was in line with trust policy and national guidelines. Eighty-eight per cent of midwives had completed the medicines management competency assessment. The service did not currently offer medicines management training for established midwives. However, the trust had introduced a new e-learning module for adult nurses. The maternity clinical educators were working to modify this e-learning module to make the content relevant to midwives, with an expected completion date of mid-2023. However, preceptorship midwives completed a medicines management workbook, which included a sign off competency assessment with an 80% pass mark,

We saw staff did not always store and manage all medicines safely. The clinical rooms where the medicines were stored was locked and could only be accessed by authorised staff. Staff checked controlled drug stocks daily. However, we found that staff did not consistently record fridge temperatures on the Birth Centre. The fridge temperature had not been recorded on 8 occasions during April 2023. We also found out of date medicines in the antenatal clinic. The matron informed us that pharmacy were responsible for checking the expiry dates and took action to remove these items.

Staff from the hospital blood bank were responsible for monitoring the temperature of the fridge used for storage of anti-D injections. This fridge was linked directly to the blood bank, and if the temperature went out of range, staff from the blood bank responded and removed any potentially affected injections.

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up-to-date. Women and birthing people had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 8 medicine charts and found staff had correctly completed them. Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

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

Staff learned from safety alerts and incidents to improve practice. Following an incident with 'to take out' (TTO) medicines, the service introduced a tracker to check women collected their medicines, if discharged without them. Wherever possible, TTO medicines were dispensed from the ward stock, following a safety check by two midwives. On occasions where medicines were not available at the time of discharge, the patient details were added to the tracker for follow up of a 4 day period, to check that the patient had collected their TTO medicines. Ward staff contacted the patient on day 1 and 2, on the 3rd day the community midwife would visit to remind the patient, with a final follow up call from the ward on the 4th day. The stock levels on the ward, particularly of medicine to prevent deep vein thrombosis (blood clots) was being increased to reduce to likelihood of women being discharged without the TTO medicines.

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. Managers ensured that actions from safety alerts were implemented and monitored.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had recognised additional resources were needed to strengthen the procedures in place to manage risk. As a result there had been investment in the development of a Quality, Risk and Safety team specifically for maternity, which fed into and was supported by the divisional team. A number of staff had been appointed to the team. This enabled the team to undertake a daily review of the incidents reported to consider the level of harm and the appropriate person to review and action. This ensured any trends or areas of increased risk were managed swiftly. Twice weekly multidisciplinary team meeting were held to review incidents, including what happened, next steps and any learning. Urgent action / learning was cascaded to staff via email, and feedback was also provided thorough the weekly Friday newsletter. This newsletter was shared with staff trust wide and included 'Learning on a page'. Staff could also request individual feedback when they reported an incident. Any themes identified through incidents were shared with the Maternity Support, Education and Training (SET) team, and incorporated into PROMPT training or added into the learning week programme.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations. Incidents classified as moderate harm were managed through the Patient Safety Incident Review Framework (PSIRF). We saw that incidents and risks were reported and discussed at board level through a variety for meetings.

The service acknowledged incidents had not always been investigated and responded to in a timely way. There were 50 incidents open over 60 days. This was against national guidance put in place to support learning and prevent events reoccurring. The service told us the number of open incidents had reduced following the investment in the Quality Risk and Safety team.

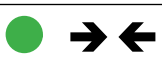
There were no reported 'never' events at this service.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and 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.

The service was aware of the criteria for reporting incidents to the Healthcare Safety Investigation Branch (HSIB) for investigation. We were told there had been no incidents that met the criteria for reporting during the last 6 months.

Managers debriefed and supported staff after any serious incident. Members of the Quality Risk and Safety team or the Professional Maternity Advocates (PMAs) were available to support any member of staff working within the maternity unit.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Maternity

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

There had been a period of instability within the maternity leadership at director level. The service had recruited an experienced interim Director of Midwifery (DoM), who was to remain in post until a permanent replacement could be been recruited and settled into the post. Staff spoke about the positive impact of the DoM on the maternity unit since their appointment.

Maternity service was a Care Unit within the Family Care Unit within the trust. There was a clearly defined management and leadership structure in place. The service was led by a triumvirate made up of the service manager, director of midwifery and clinical director.

There was clear oversight of the service with appropriate lines of reporting to various meetings, to ensure a clear line of communication between the ward and the board and any agreed actions or developments.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. They described the need to implement strengthened governance procedures to facilitate and support improvements.

Leaders were visible and approachable in the service for women and birthing people and staff.

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

The service was supported by maternity safety champions and non-executive directors. The safety champions completed a walk around on a monthly basis. Non-executive directors were encouraged to accompany the safety champions on the walk arounds, to gain insight into the complexities of the maternity unit.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The Maternity Quality Strategy 2023 – 2025 outlined the vision, the maternity strategic priorities, quality principles, and how the strategy would be delivered. The document contained a QR (quick response) code link to the maternity section on the trust website.

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The vision focused on providing exceptional maternity and neonatal care every day. The strategic priorities focused on providing exceptional care, looking after the workforce, working together to support communities, working collaboratively and using resources effectively and implementing sustainable change to improve services.

Leaders had considered the results of an assurance visit in September 2022 undertaken by NHS England team which detailed a series of actions to bring the maternity unit up to the required standards. An action plan had been put in place and progress was being made. The Maternity safety update submitted to the board in March 2023 demonstrated an improved position against Ockenden Immediate and Essential Actions (IEA's) from 39% in September 2022 to a self-assessed level of 67% in March 2023.

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.

The culture within maternity services supported staff to develop and fostered a culture of learning and improvement. Staff were proud to work for the trust and felt valued and respected by management. Staff were positive about the unit and the changes made to leadership and felt able to speak to leaders about difficult issues and when things went wrong.

Staff were generally focused on the needs of women and birthing people receiving care, ensuring their needs and voices were heard in all aspects of their birthing journey. Verbal feedback from women and birthing people supported they were very extremely happy with the care and support they had received whilst on the unit. However, we received feedback via our on-line feedback form that women and birthing people were less satisfied with the care they received once they moved to the ward environment and didn't always feel their voices were heard in respect of support with infant feeding.

The results of the Maternity Survey 2022 showed when compared to other trusts, the results were either the same as or better than expected. Many comments highlighted an overall general positive experience and thanked the midwives and other members of staff who had made a positive difference to the experience of women and birthing people. However, there were also some negative themes identified around limited choice in the birthing experience, negative interactions with staff, issues with pain management and the discharge process. Women and birthing people had mixed experiences around infant feeding and recognition of tongue-tie in babies. The service had reviewed the survey results and developed an action plan with planned quality improvement work including an induction of labour pathway, overnight triage service and expansion of continuity of care teams. The trust shared with us their staff survey from 2022. The survey was aligned to the NHS People Promise, which sets out in themes the things, that according to NHS colleagues, would most improve their workplace experience, as well as staff engagement and morale. The survey results indicated that 76% of staff would be happy with the standard of care provided and 60% would recommend that hospital as a place to work. The survey also reported on areas that had improved since the previous survey and areas that had deteriorated. Areas of improvement included flexible working, leading to a better work life balance, not being pressurised into coming to work when not feeling well, and being able to make suggestions and freedom within the role. Areas that had deteriorated included teamwork, appraisals, willingness to report bullying and harassment and retention. Staff spoken with told us that morale had improved following the appointment of the interim Director of Midwifery (DOM). Staff said the DOM was visible and approachable and was bringing about changes to improve the service.

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Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. The service had maintained the Sitwell Continuity of Carer (CoC) team to support women and birthing people in more rural areas of the county. The service also engaged with groups representing local Asian communities and the deaf, hard of hearing and deafblind community. Addressing equality and inclusion and health inequalities had become regular agenda items at meetings between maternity services and their maternity voices partnership.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. The service had received 5 complaints in the 3 months prior to the inspection. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Maternity and Neonatal Safety Champions Meetings took place monthly. Standard agenda items included safety dashboard review, training and education, feedback from the staff safety forum and board walkrounds, feedback from the Maternity Voices Partnership, maternity governance and safety and safety improvement activity /action. Oversight of maternity services was provided to the board by the Chief Nurse / Safety Champion bi-monthly.

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.

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

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues.

There were opportunities for managers to meet with the senior management team on a regular weekly and monthly basis, and key areas including performance, staffing and incidents were discussed in these meetings.

Staff and leaders could clearly articulate the governance framework for the Care Unit and how information flowed between maternity services and the board, and from the board back to the ward.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. Maternity Quality Governance Group meetings were held monthly. We looked at meeting minutes for the last 3 months which provided details of the meetings, national reporting requirements and reviews of any risks in relation to staffing and incidents.

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Senior leaders managed workforce planning plans well. The service had commissioned an updated staffing and acuity review, which was due to report in June 2023. The service's current staffing levels already exceeded the number identified as required in the previous staffing review. Leaders were proactively looking at managing potential staffing shortfalls over the summer months. Staffing across the maternity unit and community was discussed on a daily basis, enabling the service to proactively manage any staffing shortfalls in line with planned activity.

Senior leaders in maternity met weekly. The triumvirate told us they had recently commenced a running action log for these meetings. Senior matrons and team leaders were also given the opportunity to meet weekly to discuss any issues and updates.

There was an effective policy in place to manage the department when it was in escalation. We looked at the policy and saw there were clear actions in place to mitigate risks and manage levels of staffing to the needs of patients. We also saw how systems were in place to escalate staffing concerns across the maternity units to reduce any day-to-day risk.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders had RAG rated policies to identify those overdue, coming due and within date. The service had identified 29 policies that were overdue for review, 17 of which were out for review. We saw policies were discussed at the Maternity Quality Governance Group meetings. Two of the policies we reviewed during the inspection had not been reviewed since 2021. However, the content of both policies was appropriate.

Management of risk, issues and performance

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

The service participated in relevant national clinical audits. The service was working towards ensuring that outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The service had developed on audit programme for 2023/24 with support from the Clinical Effectiveness Team. The audit plan was subject to review and amendment, dependent on service need, publication of new guidance or themes or trends of incidents. Proposed changes would be reviewed by the Care Unit and Divisional Governance, and any amendments overseen by the Clinical Effectiveness Group.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service was an early adaptor of the *Patient Safety Incident Response Framework* (*PSIRF*). The service had an incident management policy which showed the flow of action from receipt of the incident, which detailed the action against the severity of incidents. Twice weekly multidisciplinary team meetings were held to carry out rapid reviews of incidents categorised as moderate harm. All incidents were reviewed and it detailed the criteria for the national reporting framework. We reviewed the policy and saw the procedure had been followed.

Staff told us that learning from incidents was shared with staff via 'Learning on a page' which formed part of the weekly newsletter. We saw examples which clearly identified any learning as well as next steps.

The service worked with MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) to ensure they reported any maternal deaths. We saw the service reviewed all the information and this was shared with the board, seniors, and staff to reflect on learning.

There was an effective robust system in place to review and monitor actions from HSIB (Healthcare Safety Investigation Branch). The service had no new HSIB cases from the last the last 6 months. The central patient safety team had undertaken an initial review of all HSIB reports, was due to report to the maternity multidisciplinary team meeting on 18 May 2023 to agree themes and develop an improvement delivery plan.

The service had a risk register in place. We reviewed the risk register and saw the service had recorded relevant risks rated as high or extreme risks. Against these was the mitigation actions and actions to address the risk. The register stated clear ownership of the risk, timescales for review or completion.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. A total of 4 out of the 10 safety standards had been completed. An Action Plan and a bid for funding had been put forward to help increase support for the Clinical Negligence Scheme for Trusts (CNST) requirements. The service maintained an ongoing action plan which was monitored along with being reviewed as a risk whilst it had not met all 10 standards.

The service was working towards compliance with the saving babies lives care bundle and complied with 3 out of the 5 elements. Overall compliance with the 5 elements was 86% in May 2023, which had improved from 70% in January 2023.

We reviewed the trust's compliance with the perinatal clinical quality surveillance model. The tool was used to strengthen trust-level oversight for quality and taking proportionate action and triggering escalation.

The service managed and monitored any closures. There had been one occasion within the last 12 months when the unit closed for one and a half hours and alterative arrangements were made for women and birthing people.

Information Management

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

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

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

The service used an electronic recording system which was password protected for each staff member, this ensured they were secure**.**

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

Engagement

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

Leaders worked with the local Derbyshire Maternity and Neonatal Voices (DMNV) to contribute to decisions about care in maternity services. Maternity voices partnership engagement meetings were scheduled quarterly and covered feedback, ongoing projects, or developments within maternity, along with new initiatives and community work.

We reviewed the minutes of the most recent meeting. We saw a range of topics were discussed. There was a positive relationship between the service and DMNV. The service were positive about their relationship with DMNV and valued their support and input with improvement work. There was shared working around developing guidance for women and birthing people and reaching out hard to reach communities. The DMNV had supported the service to review and update their website.

The DMNV had completed 15 steps review in November 2022. The team included representatives from groups representing local Asian communities and the deaf, hard of hearing and deafblind community. This quality tool reviewed the service from the perspective of people who used maternity services. Any elements raised from the 15 steps were reviewed and actions developed with completion dates. Some recommendations had already been actioned, for example clear posters on Trinity ward of where to turn to if you have a concern, with designated contact details. In addition, a 'how to contact the matron card' had been produced and was laminated and placed beside each bed space.

Following feedback from women and birthing people the DMNV had worked closely with the service to look at women's understanding and experience of induction of labour. The DMNV had supported a focus group firstly with parents and then joined by midwives, followed by a survey. They told us they received 450 responses in relation to induction of labour. The Senior Matron for Intrapartum and Antenatal Day Services was driving the project, and the DMNV were excited about the possibility of change in the future when women were more informed about induction of labour.

The service made available interpreting services for women and birthing people and pregnant people. Staff told us they booked face to face interpreters when required and also had access to a telephony based interpreting service.

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.

The service was 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 changes through training and innovation. Staff told us that management was very receptive to suggestions regarding education, training and development of staff.

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The service had links with local universities. The lead midwife for fetal monitoring told us they were working with the universities to set up a cardiotocograph (CTG) club for students, to assist with their learning and development prior to registration.

The service had introduced a Band 4 Maternity Support Worker (MSW) Transformation Lead across all areas to support continuity of carer, digital and service transformation. There was a commitment to provide training for MSW staff up to Level 3 in Health and Social Care with relevant maternity modules, with the aim upskilling staff to support midwives and enhance care provision.

There were plans to further develop the preceptorship programme for newly qualified midwives. This included reviewing and updating the Band 5 competency package to reflect changes in practice, and better support the progression to band 6 status. The service was trialling block rotations to different areas of the service, for example: antenatal clinic, pregnancy assessment unit and community to better prepare staff for a band 6 role.

The service produced and circulated newsletters called 'Feedback Friday' to staff weekly. We saw these provided a combination of information, appreciation, and thanks, as well as opportunities for support or wellbeing. Maternity Quality and Risk Safety resource folders were available in each area and contained relevant updates and information and copies of the newsletter. The folder we looked at included the guidelines for thromboprophylaxis in pregnancy, information about the Patient Safety Incident Response Framework (PSIRF): the new process, the benefits and how it had changed the response to incidents; red flag indicators and learning on a page. The top 5 risks in maternity had also been shared with staff in the weekly newsletter.

The service did not hold formal minutes Quality Improvement meetings. However quality improvement initiatives were discussed at the monthly Maternity Oversight Group meeting.

Outstanding practice

We found the following outstanding practice:

- The safeguarding team identified 7 concealed pregnancies in a 6 month period. A review of the records did not identify any themes or trends for these women. The safeguarding team also accessed the Child Protection - Information Sharing Service (CPIS) for women outside of area. This service provided a network across the country of women or their babies who could be at risk.
- Staff from the hospital blood bank were responsible for monitoring the temperature of the fridge used for storage of anti-D injections. This fridge was linked directly to the blood bank, and if the temperature went out of range, staff from the blood bank responded and removed any potentially affected injections.
- The service had introduced a senior Maternity Support Worker (MSW) role across all areas to support continuity of carer, digital and service transformation. The senior MSWs work as transformation leads for the MSW workforce. There was a commitment to provide training for MSW staff up to Level 3 in Health and Social Care with relevant maternity modules, with the aim upskilling staff to support midwives and enhance care provision.

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Areas for improvement

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

Action the service SHOULD take to improve:

Chesterfield Royal Hospital:

- The service should continue delivering the learning week programme as planned to ensure training targets are met.
- The service should continue to monitor that all staff are up to date with safeguarding adults and safeguarding children training at a level appropriate to their role.
- The service should continue to monitor that all mandatory training meets the trust's targets.
- The service should provide pool evacuation training for staff who assist with water births.
- The service should review handovers on the Birth Centre to identify if improvements to maintaining confidentiality can be achieved.
- The service should ensure daily checks are completed and recorded for the fridge temperatures and emergency trolley on the Birth Centre.
- The service should investigate all incidents without delay in line with trust policy.
- The service should consider implementing a structured approach to all handovers between clinical staff.
- The service should continue to monitor staffing levels to ensure all clinical areas are adequately staffed to provide safe patient care.
- The service should ensure that policies are up to date and reviewed in accordance with the review date.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 3 other CQC inspectors. There were 2 specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Healthcare.