Northern Lincolnshire and Goole NHS Foundation Trust

Goole & District Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Goole & District Hospital

Good 

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

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of maternity services for women at three acute hospital sites.

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

The Goole Hospital provides maternity services to the population of East Riding. There are high levels of deprivation with North East Lincolnshire being one of the 20% most deprived areas in England and 26% of children living in low income families.

The maternity service at Goole is a small standalone birthing unit which offers a home from home low risk midwifery-led unit, run by community midwifery teams and offering antenatal clinics, and an on-call childbirth service for women and pregnant people who want a step up from a home birth. The unit had one delivery room with a birthing pool. There are no other inpatient obstetric or neonatal services onsite. The unit therefore supports low risk women and birthing people who want a birth in a 'home away from home' setting. Those considered high risk are transferred to Scunthorpe General Hospital (the consultant led unit) for delivery.

A weekly obstetric clinic is available for women at Goole District Hospital who meet high risk criteria and need consultant led care closer to home.

Between October 2022 and October 2023, 6 babies were born at Goole and District Hospital midwifery led unit (MLU).

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 our full comprehensive inspection programme in November 2019. The overall rating was good.

Our rating of this hospital stayed the same. We rated it as Good.

How we carried out the inspection

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

Our findings

We visited the Goole midwifery led unit (MLU).

We spoke with 4 midwives and 1 midwifery support worker. We were unable to speak with any women, birthing people, birthing partners or relatives. We received no responses to our give feedback on care posters which were provided to the service to display and share with people during the inspection.

We reviewed 3 patient care records and 2 medicines records. We also interviewed key members of staff, medical staff and the senior management.

Following our onsite inspection, we spoke with senior leaders who were responsible for the leadership and oversight of 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

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. They understood how to protect women and birthing people from abuse, and managed safety well. Staff were competent for their roles.
- The environment was suitable, and the service had enough equipment to keep women and birthing people safe, and the service managed infection risks well.
- Staffing levels met the planned numbers and the service worked on a permanent on-call basis when required.
- Records were complete and up to date. Staff managed medicines well.
- The service managed safety incidents well and shared lessons from them.
- Leaders and senior staff had the necessary experience and knowledge to lead effectively. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff and leaders were passionate about providing safe care and promoting the use of the MLU.
- Staff were competent and understood their roles and accountabilities. They were focused on the needs of women and birthing people receiving care. Staff felt respected, supported, and valued. The service supported equality and diversity and there was an open culture and the service encouraged people and staff to raise concerns.
- Leaders were visible and approachable in the service for women and birthing people, and staff. Executive leaders had oversight of service data and operated governance processes.
- Staff understood the service's vision and values, and how to apply them in their work. They were committed to learning and improving the service. The service engaged well with women, birthing people, and the local community to plan and manage services.

However:

- Not all staff had completed training safeguarding specific for their role on how to recognise and report abuse.
- Midwives carried out, but did not record, alternated auscultation of the fetal heart rate during labour. This was not in line with trust policy.
- There was insufficient assurance that leaders had oversight specific to the MLU on audit, or risks to birthing people and babies.

Is the service safe?

Requires Improvement ↓

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

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

Maternity

Midwifery staff received and kept up to date with their trust-wide mandatory training. The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training compliance rates for the midwifery led unit (MLU) were included in the figures for the Scunthorpe community midwifery team. Data showed that overall, 85% per cent of clinical staff had completed mandatory training courses, which met the trust target.

Mandatory training modules included elements of equality, equity and personalised care and opportunities for staff to extend their learning and understanding of health inequalities. This included unconscious bias and mental health awareness. In addition, training compliance was 100% for midwives and maternity support workers attending a personalised care study day which included but was not limited to perinatal mental health, smoking cessation, infant feeding and bereavement.

There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. Midwives completed fetal monitoring (cardiotocograph (CTG)) training, which included intelligent intermittent auscultation, human factors and physiology and CTG interpretation and staff completed a supervised competency assessment at the end. Records showed 95.2% of midwives had completed the fetal monitoring aspect of training.

The service made sure staff received multi-professional simulated obstetric emergency training. Records confirmed that 95% of midwives had completed this and 100% of midwives had completed the newborn life support training. Also, 87.5% of maternity support workers had completed this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service produced a training needs analysis in 2021 which was updated in November 2023 and planned maternity training in line with national and local requirements and based on themes identified by incident reviews and audits. Staff said they received email alerts, so they knew when to renew their training.

The service had a midwifery education team which was overseen by a lead practice educator working across all 3 trust sites, including the community team. They were supported by clinical skills midwives and a preceptorship legacy midwife.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse to the level appropriate for their role.

Most staff received training specific for their role on how to recognise and report abuse. Training records submitted in November 2023 showed 67% of staff had completed Level 3 safeguarding children training with a further 13% of staff booked for the February 2024 training sessions and 20% booked for April 2024. Training records for adult safeguarding showed 81% of staff were compliant to level 2 only. Managers provided information to show more staff were booked to attend level 2 training up to 6 months in the future. All staff involved in planning and risk assessing care in maternity should be trained to level 3 for adult safeguarding as set out in the trust's policy and in the intercollegiate guidelines. Therefore, we were not assured the relevant clinical staff had completed the right level of adult safeguarding to identify women and pregnant people at risk of abuse, or that the service could provide sufficient or timely training.

Maternity

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

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

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, and staff used a safeguarding flag system to ensure all staff were made aware of any concerns raised.

Staff followed safe procedures for children visiting the ward. Staff completed simulated baby abduction training and the service displayed posters to alert people to the risks. Also, doors were secure.

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 managed infection risks 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.

Staff described the MLU as a “birthing suite”. It incorporated a delivery room with homely furnishings, a birthing pool, and a bathroom with a toilet and shower. All areas of the MLU were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

The service generally performed well for cleanliness. Infection prevention and control environmental records for November 2023 showed overall compliance was 90%, staff checked equipment, kitchens, sharps disposal and various other aspects of the environment.

Staff disposed of clinical waste safely. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. Data for July to October 2023 showed compliance was consistently at 100%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and staff used “I Am Clean” stickers to show it was ready for use.

Environment and equipment

Maternity

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

Staff described the MLU as a birthing suite. It incorporated a delivery room with homely furnishings, a birthing pool, and a bathroom with a toilet and shower.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff carried out safety checks of specialist equipment. All equipment checks had been completed on the day of the inspection. Records showed adult and neonatal resuscitation equipment was checked weekly. The April to November 2023 resuscitaire checklists showed staff checked of resuscitaires every week, except for the month of September because the checklist was missing. There was no information provided to show if emergency equipment checks were audited.

Staff followed a process for cleaning the birthing pool after use. Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. The estates team carried out regular flushing of seldom used water outlets and, in addition, MLU staff flushed the birthing pool taps 3 times a week. Staff completed electronic records of all water flushing in line with hospital policy.

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. A laryngoscope we checked had a flat battery and staff replaced this during the inspection. There was a portable ultrasound scanner and a sonographer carried out first trimester scans. The service provided a pool evacuation net and staff attended a water birth study day which included management of a maternal collapse in the pool and emergency evacuation.

Medical obstetric emergency kits including anaphylaxis kits with adrenaline were available and in date. If emergency medical assistance was needed there was a resident registrar in the hospital at all times and staff could use the central 2222 line to call for immediate support. If a more serious or obstetric emergency occurred staff would call an ambulance to transfer the birthing person or baby to the consultant led unit.

External mental health service partners had been commissioned to undertake risk assessments. The ‘management of ligature risks’ assessments report (April 2023) showed there were no mental health services within the hospital. Staff working on the MLU were aware of risks and trust leaders continued to monitor ligature safety throughout the hospital.

Assessing and responding to risk

Not all antenatal screening had been completed, therefore leaving an incomplete picture of risk prior to births. However, 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.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Midwives reviewed care records from antenatal services for any individual risks. Service leaders did not provide evidence of individual maternity care audits for Goole MLU. They told us the audits were

completed trust wide and could include some records from Goole, but the records provided did not reflect this. Care records audits for 2021 and 2022 completed at the consultant led unit showed low compliance with numerous aspects of risk assessing. For example, only 50% of records completed at booking had carbon monoxide (CO) screening. Risk category status was not recorded in 35% of records and only 60% of women had the appropriate mental health referral made to the specialist midwife. This meant we were not assured women and pregnant people requesting birth at the Goole MLU had been adequately risk assessed. It was not clear if care was aligned to national guidance or audit and followed the saving babies lives care bundle.

Staff knew about and dealt with any specific risk issues. Staff followed the 'Goole Freestanding MLU' trust guidelines which linked to the Midwifery Led Care Guideline, and national guidance to make sure women were fit for childbirth within this 'low risk' environment and made referrals to obstetric colleagues when they identified deviations from normal health. Staff offered women and pregnant people a birth plan appointment between 36 and 38 weeks of pregnancy, where they discussed coping strategies during childbirth and discussed access to the midwife led unit and reasons for transfer.

The service made sure women and pregnant people received one to one care during childbirth. Two midwives were present during birth and used intelligent intermittent fetal monitoring equipment during labour in-line with local and national guidance and the service had developed a clinical pathway for staff to follow to enable identification and escalation of risk. As a low-risk MLU, the two attending midwives alternated auscultation although they did not record this. This meant there was no record of this having taken place. At the end of our inspection, we gave feedback to staff and senior midwives who said attending midwives would begin to record this immediately following the inspection.

Staff referred women and pregnant people who chose to give birth outside safety guidance to the obstetric team for a review of care and to make sure the risks were discussed and reduced.

The trust had introduced a 24-hour dedicated maternity triage telephone service to make sure women and pregnant people could access services when they needed them. Records showed how many calls resulted in attendances and included feedback from patients.

Community midwives triaged women and pregnant people at home when they called because they thought their birth had started, this was because the model was a home from home service. However, leaders told us a Quality Improvement Project had commenced in 2023 with an aim "To Implement a fully operational maternity triage service across the whole of the Maternity Service, that utilised a Nationally recognised triage model by October 2023. The aim was to improve patient experience and staff satisfaction."

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as a partogram to plot maternal and fetal wellbeing during childbirth. But staff did not use the maternal obstetric early warning score (MEOWS) at any point during childbirth, which is nationally recognised as an important tool to help staff recognise the early deterioration of maternity patients. Leaders stated this tool was only used in the acute setting at the main hospital.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Leaders told us the birthing person and baby 'should remain at Goole MLU until the midwife is satisfied, they were in a stable condition (not less than one hour)'. MLU staff could access electronic paperwork care if required to support and record enhanced midwifery to ensure babies born in poor condition had the correct monitoring whilst awaiting transfer.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

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 all staff involved in the birthing person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used a recognised situation, background, assessment, recommendation (SBAR) tool if any birthing person or baby required a transfer to another unit.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. There was a daily meeting with all community midwives on duty where key information was shared.

The service did not provide transitional care for babies who required additional care because it was a standalone MLU. The service transfer policy showed, and staff told us, babies who needed additional care would be transferred to the acute unit at the consultant led unit.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge. Staff issued discharge notifications for community midwifery teams, GP's and health visitors.

Leaders made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff followed the 'Maternal Transfer by Ambulance (Intrauterine Transfer, Transfer From Homebirth To Hospital & Transfer Postnatally To Another Unit)' guidance, when transferring people to the main hospital unit. Staff called the main unit to discuss care with the labour ward co-ordinator or obstetric team, in the event of an emergency staff called an ambulance to safely transport labouring people, and where applicable their newborn babies. There had been 2 transfers from the MLU to the consultant led unit in the previous 12 months, both for failure to progress during labour. One[SW1] [JA2] baby was delivered delivery safely during the transfer. Staff followed the MLU policy provided, and for all transfers two midwives travelled to the receiving hospital.

Midwifery Staffing

The service had enough staff to care for birthing people and babies. Staffing levels matched the planned numbers.

Managers accurately calculated and reviewed the number of midwives and maternity support workers needed for each shift in accordance with national guidance. Leaders had completed a staffing and acuity assessment for Goole MLU in 2022 and then measured this through the monthly staffing report from the chief nurse and records confirmed this. Staffing was provided via the consultant led unit community teams. This review recommended 20.6 whole-time equivalent (WTE) midwives and 3 WTE maternity support workers.

The number of midwives and healthcare assistants matched the planned numbers. Reports for October 2023 showed the midwife to birth ratio for Consultant led unit which included Goole MLU was 1:27.7 which was just below (better than) the recommended ratio of 1:28. There was a supernumerary shift co-ordinator on duty at the consultant led unit around the clock. They had oversight of the staffing, acuity, and capacity. In the event of staff absence managers

followed the 'Maternity Service Escalation Policy', completed a risk assessment to identify risk issues and moved staff according to patient need. Senior midwives told us staffing showed an improving trend over the past 6 months, and community teams, including MLU staff, were now less likely to be asked to cover shifts at the consultant unit during staffing escalation.

Staffing levels matched the planned numbers, ensuring the safety of women and birthing people and babies. On the day of inspection there were 5 midwives, 4 midwifery support workers and an administrator on duty. They were responsible for community and antenatal care. On-call midwives staffed the MLU. Managers and staff told us the MLU followed home birth protocols for staffing and if a birthing person wished to use the MLU, 2 midwives would always be required to attend the unit to carry out their care. This could include a midwife already present at the MLU, but in most cases on-call midwives only. This meant that if 2 midwives were not available, a home birth or MLU birth could not be accommodated. Birthing people had a named midwife throughout their labour and delivery. If a midwifery support worker was available, they could provide additional support for the MLU. Midwifery support workers told us they enjoyed this part of their role.

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. Between November 2022 and October 2023 there were no red flag incidents.

Senior midwives had the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. Records showed there was a low backfill rate at Goole MLU. They had no need to use bank or agency staff and senior midwives remained supernumerary.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. A trustwide practice development lead midwife supported midwives. The team included one off-site practice development lead midwife. Records showed that 100% of midwives received their annual appraisal.

Managers made sure staff received any specialist training for their role. We met student midwives on placement who said they had been made to feel welcome, valued, and a part of the team. They had a named practice assessor and practice supervisors, and they had been involved in developing a birth plan. In October 2023 all MSW were re-banded to band 3.

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 electronic and paper records. Antenatal records were electronic and available to all authorised staff via computers throughout the service. Staff on the MLU used paper records to record care during labour. We reviewed 3 records and found records were clear and complete.

Maternity

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

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

Medicines

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

Staff completed medicines management training and followed systems and processes to prescribe and administer medicines safely. Records showed that 91% of midwives completed this. Women and birthing people had paper prescription charts if medicines needed to be administered during their admission.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit. We reviewed 2 medicine records and found there were no omissions.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. There was a very limited stock of medicines in keeping with the low number of births that took place. This meant wasted medicines were kept to a minimum. Medicines were in date and stored in a fridge or locked cabinet. Trust pharmacy staff had advised staff there was no need to record room temperatures. However, staff monitored and recorded fridge temperatures and knew to act if there was variation. Staff did not store or issue controlled drugs within the unit.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines were recorded on both paper and digital systems.

Staff learned from safety alerts and incidents to improve practice.

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.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. There were no incidents reported in the 3 months before inspection and we found no incidents remaining open for more than 60 days and there had been no 'never' events.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers reviewed incidents across the maternity service potentially related to health inequalities.

Maternity

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. There were no serious incident investigations at Goole MLU within the reporting period November 2022 to October 2023. In the event of a serious incident staff would involve birthing people and their families in the investigations.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. Staff shared learning from incidents and serious incidents that occurred in other areas of the service, including updates to local guidelines and actions for staff to take to prevent their recurrence. Staff reported serious incidents clearly and in line with trust policy. Staff used an online reporting system to record and report incidents. These were sent to relevant managers to review and delegate.

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.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, managers displayed overviews of incident investigations in staff areas which included conclusions and identified learning outcomes. The information was bordered in red so that staff could clearly identify the updates. The maternity and neonatal safety champions produced a monthly bulletin which showed recent safety themes, training and links to their email boxes.

Managers debriefed and supported staff after any serious incident. Staff told us they felt supported by managers and colleagues and knew how to gain support when things went wrong. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. There was evidence that changes had been made following feedback. Staff explained and gave examples of additional training implemented following a medication incident within the service.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Local leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for women and birthing people, and staff. Executive leaders had oversight and collected data, although this was not always specific to the MLU.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. The family services division was overseen by a quadrumvirate, which consisted of the associate chief nurse for

maternity, gynaecology and breast, the associate chief operating officer, the divisional medical director and the associate chief nurse for children's and young peoples and neonatal services. Local leaders included the community matron and MLU manager had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them, which were shared with staff.

Leaders were visible and approachable in the service for women and birthing people and staff. We found leaders had clear roles and responsibilities, were well respected, and supportive. Staff told us they were well supported by their line managers, and ward managers. The executive team visited the hospital on a regular basis.. Following the inspection the service told us staff had remote access to a 'Family Chat' meeting which they could attend when desired.

The maternity leadership team met regularly and formally.

The service was supported by maternity safety champions and non-executive directors. The chief nurse was the board safety champion, who was supported by a non-executive director (NED). They were responsible for acting as a conduit between frontline safety champions and the trust board and monitored maternity and neonatal services. The maternity safety champions kept an action log of identified issues from concerns about the estate to discrepancies noted in guidelines. Each point had an identified lead and timeline for completion. Although there were mostly main site issues, some were trustwide, but none were specific to Goole MLU.

Staff gave examples of joint working between leaders across disciplines within the service, across sites and different specialties within the trust. They also worked with external bodies, agencies and other trusts to ensure care provision for women, birthing people and babies.

They supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress.

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. They had developed the vision and strategy in consultation with service users and staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and had revised the maternity strategy to include working towards compliance with national programmes, reports, and recommendations. The maternity strategy focused on 5 key priorities which were;

1. To provide excellent, 'evidence based' care to all
2. Investing in the workforce
3. Listening and working together with service users
4. Supporting maternity transformation

5. Embed the quality improvement agenda in all aspects of the service.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy up to 2026, which included the Goole MLU. Managers and staff understood the role and importance of offering the home from home service.

Leaders and staff understood and knew how to apply them and monitor progress. There was a maternity strategy for 2023 to 2026 which outlined the purpose and vision to provide high quality, evidence-based care ensuring "women and their babies are at the heart of everything we do". Posters and documents displayed within the unit were headed with the service values of "Kindness, courage and respect" and staff were encouraged to be part of any change within the values framework. At the last inspection there had been concerns about sustainability of the service, but at this inspection there were very clear expectations of how the Goole MLU should function. Staff and leaders were passionate about providing safe care and promoting the use of the Goole MLU. The unit was opened only when a birthing person wished to use it, and it was staffed, stocked, cleaned, and equipped accordingly.

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 birthing people, their families and staff could raise concerns without fear.

Staff working on the MLU felt respected, supported, and valued. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Records showed an action plan for the 2022 maternity wide staff survey, actions were allocated to a lead and time frames were set for reviews. Actions included psychological support, opportunities to raise care issues, breaks, maternity behaviour charter and ensuring lessons from incidents were disseminated to all staff. The action plan showed most actions were ongoing, and at the time of our inspection the 2023 staff survey was due to be carried out, therefore we are unable to report if the action plan was affective. Leaders told us they felt very proud of the service, and that it was a safe service which met the needs of the local population. They said, 'midwives are passionate about their work out there'.

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

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. Staff said that it helped them understand the issues and provide better care. The NED explored links with transient military families to enable and promote care of birthing people and babies in local military personnel communities.

Maternity

Safety champions conducted monthly walk arounds across the maternity and neonatal services alternating the site venue each time. The patient safety midwife ran a 'Shout Out Wednesday' event each month to enable escalation by all staff of any safety concerns. They provided safety mailboxes, open to all, maintained an action log, and updated this as part of their walk arounds. There were no actions regarding community staff who rotated into the MLU to provide care during childbirth.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The 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. 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 birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them. Staff told us they felt able to raise concerns and they would be listened to.

Managers investigated complaints, identified themes and shared feedback with staff. Learning from these was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and birthing people received feedback from managers after the investigation into their complaint. Records showed there were no complaints from August to November 2023 about Goole MLU.

Governance

Leaders operated governance processes, throughout the service and with partner organisations but some were not specific to the Goole MLU. Leaders managed compliance, performance, improvement, or providing monitoring information and oversight for the service. However, due to the size of the unit, not all information was specific to the MLU. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet.

Leaders operated effective governance processes, throughout the service and with partner organisations. There was a 'Trust-wide' governance structure which supported the flow of information from frontline staff to senior managers over all divisions within the hospital. The governance structure comprised of 16 groups, with 16 sub-groups or committees, that fed into the trust wide quality governance group, and reported to the Quality and Safety Committee and the Trust Management Board. There were divisional governance groups, and maternity services were part of the Family's division. The Goole MLU representation was in partnership and oversight of the consultant led unit maternity quality team. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The maternity services and Family Services Division created a fixed meeting and reporting structure and records confirmed this. The maternity operational dashboard underpinned the central quality governance functions and fed up the structure with weekly quadrumvirate, incidents and divisional board meetings and monthly quality improvement and monitoring meetings. The outcomes fed into the 'Family Services' risk register which was reviewed by the obstetrics and gynaecology governance group which met monthly. Also, there were various governance oversight meetings that

included, the maternity transformation and Improvement board, the quality board and the trust quality and safety committee and family services performance review and improvement meetings. These boards reported to a trust wide sub-committee and the trust board. Records confirmed that leaders recorded minutes for these meetings which included attendees, outcomes and planning. However, there was limited specific information about Goole MLU.

Service leaders did not provide evidence of individual maternity care audits for Goole MLU. They told us the audits were completed trust wide and could include some records from the Goole MLU. Care records audits for 2021 and 2022 completed at consultant led unit showed low compliance to numerous aspects of risk assessing. For example, only 50% of records completed at booking for carbon monoxide (CO) screening during pregnancy. Risk category status was not recorded in 35% of records and only 60% of women had the appropriate mental health referral made to the specialist midwife. This meant we were not assured that women and pregnant people requesting birth at the Goole MLU had been adequately risk assessed, because we were not assured that care was aligned to national guidance and audit and followed the saving babies lives care bundle.

During our reviews of trust wide maternity service audits and Maternity and Neonatal Oversight reports from September to December 2023 and the 'Family Services Senior Management Meeting' we noted there was no mention of the midwife led unit at Goole. The 'Obstetrics & Gynaecology Governance Group' minutes did have a section for reporting on each location, although this appeared to be about issues regarding the estates and gynaecological services not the Goole MLU. This meant there was a lack of meaningful data for the Goole MLU. We recognised this was a small service with a low birth rate, however because of this we would expect robust monitoring and oversight in line with national recommendations.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. Minutes from the obstetric and gynaecology meetings confirmed leaders reviewed and approved clinical, non-clinical guidance and patient information leaflets to ensure they reflected evidence-based practice.

However, records provided by trust leaders showed slow progress in 2023 for maternity services aligning with the 15 recommendations, which included 90 sub- actions made by the Ockenden report 2022. There were still 28 sub actions rated as action when data was sent to us in December 2023. Most outstanding actions revolved around workforce planning and sustainability. Following our inspection, the service provided information from a local maternity and neonatal system trust review visit to Scunthorpe Hospital in October 2023 which included information about the community midwifery teams. The outcome of the review demonstrated positive results towards the network's assurance for scanning and onward referral of cases in antenatal care as well as mandatory training processes supporting the achievement of trust targets. Areas for improvement included staff sustainability, governance, and the use of data to drive improvement.

Management of risk, issues, and performance

Maternity

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant service-level risks and issues and identified actions to reduce their impact. However, there was insufficient oversight of risk specific to the Goole MLU. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Trust-wide the service participated in relevant national clinical audits. These included the MBRACE – UK Perinatal mortality surveillance report and Maternal Morbidity confidential Enquiry. The divisional governance lead produced a monthly 'Perinatal Maternity Review Tool (PMRT) newsletter which showed required learning because of themes found during incident reviews. For example, the October 2023 newsletter reminded staff to ensure ethnicity was reviewed so women and pregnant people from minority ethnic groups were put on the correct care pathways.

Managers and staff carried out repeated audits to check improvement over time. They audited performance and identified where improvements were needed. Records showed trust-wide maternity services had 14 planned audits for the year April 2023 to March 2024. Included in this audit was the maternity audit dashboard which included trust-wide indicators for maternal clinical care, neonatal clinical care, stillbirths and public health indicators.

Outcomes for birthing people were mainly positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. However, the presented data was trust-wide was not always presented in percentages to reflect national targets, for example the quarter 3 October to December 2023 dashboard, therefore, we were unable to identify incidents like perineal trauma which occurred within the Goole MLU.

The division's risk register did not have any recorded risks that specifically mentioned the Goole MLU. Data showed the unit was used infrequently, staffed by a permanent on-call system. The potential risk was there was no separate audit data for births at the Goole MLU and no clear audits for equipment and environmental checks. For example, there was no recent environmental risk assessment for the unit.

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. We observed quality improvement messages and information boards showing current performance and goals for improvement.

Maternity leaders presented trust-wide data sets to the board. However, we did not see Goole MLU specific data.

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

There were plans to cope with unexpected events. They had a detailed local maternity escalation plan. Leaders described the birth centre as a 'pop up service' Community midwifery teams had an 'on-call' system to cover the Goole MLU for childbirth and opened when requested. The birth rate for the service was 14 for the period November 2022 to October 2023. This included 6 births at the MLU, and 2 cases transferred to the consultant led unit. Because the birth rate was low, the midwifery unit was generally closed overnight.

Leaders implemented a policy for lone working. Although 2 midwives attended each birth for safety reasons. Midwives followed the 'Goole Freestanding MLU' policy which included information on how to transfer women to the main hospital when required. When transfer did occur, staff completed an incident form.

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

Information Management

The service collected reliable data and analysed it. 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.

However, the patient record information systems were not fully integrated the trust used a combination of paper and electronic records**.** This was not in line with national guidance or current NHS digital guidance. Although, this risk had been recorded on the Family divisions risk register and leaders and agreed funding in November 2023.

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

Engagement

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

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP chair had very recently been appointed and had only been in post for 1 month at the time of the inspection. They said they had already been involved in attending community groups, a listening event, and work with a local father's group with the aim of providing a father-inclusive service. They spoke about reaching out to seldom heard voices from LGBTQ+ groups, different cultural and religious communities and working with the trust engagement leads to reach out.

The service always made available interpreting services for women and birthing people and collected data on ethnicity. MVP staff planned to promote equity and access to information by putting a QR code sticker on birthing people's notes to enable them to access information in their own language, although there was no timeframe or formal process in place at the time of the inspection.

Leaders understood the needs of the local population. MVP staff were also aware of high levels of poverty in the area and further difficulties experienced by families who were unable to afford for electronic equipment to access information or travel costs to attend events. However, although staff said they were committed to making changes, there were no plans in place to turn this awareness into actions.

The service worked with external organisations and monitored actions and recommendations from CQC, NHSE, and Maternity and Newborn Safety Investigations (MNSI).

Maternity

There were information boards on corridor walls in all clinical areas. There was a summary of user feedback, comments and actions taken. Details of how to get different types of support, make a complaint, and give feedback.

We received no responses to our give feedback on care posters which were provided to the service to share with women and birthing people and were in place during the inspection.

Leaders told us the community teams met every 2 months to discuss care, allow a platform for debrief, share information on incidents, feedback, patient experiences and risks, new guidelines, and updates. However, they did not keep minutes and advised there was no feedback. Therefore, we are not assured that all staff had the opportunity to raise concerns or discuss feedback from learning.

Learning, continuous improvement and innovation

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

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

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies. A family division Quality Improvement Group met monthly to look at areas for improvement. However, we did not see any evidence of Goole MLU quality improvement projects.

Areas for improvement

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

Action the service MUST take to improve:

Maternity

- The service must ensure all MLU staff complete the appropriate level of Safeguarding Adults and Children training in line with trust policy and intercollegiate guidelines. Regulation 12 (2a)
- The service must ensure staff complete an annual environmental risk assessment to demonstrate that the MLU has the appropriate safety checks. Regulation 15 (1) (e)
- The service must follow national guidance for risk assessing birthing people and newborn babies at every interval of care. Regulation 12 (2)(a)(b)

Action the service SHOULD take to improve:

Maternity

- The service should undertake timely reviews of audits to ensure findings and recommendations are followed up to ensure learning and improvements.

Our inspection team

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