Calderdale and Huddersfield NHS Foundation Trust

Calderdale Royal Hospital

Inspection report

The Calderdale Royal Hospital
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Ratings

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

Our findings

Overall summary of services at Calderdale Royal Hospital

Good 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Calderdale Royal Hospital.

We inspected the maternity service at Calderdale 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.

Calderdale maternity service has approximately 4000 births a year across the labour ward and co-located birth centre. The labour ward had 11 birthing rooms, one of which had a birthing pool and the birth centre had 7 birthing rooms, 2 with birthing pools. The service also had 4 transitional care beds and a neonatal unit. There was 1 dedicated maternity theatre and a second that could be used in an emergency.

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.

Calderdale Royal Hospital maternity service is rated Good.

How we carried out the inspection

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 completed training to ensure they had training in key skills, they worked well together for the benefit of women and birthing people and 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 digital 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. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care and creating an inclusive environment to meet people's needs. 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. Staff were committed to improving services and addressing health inequalities for women and birthing people.

However:

- Staffing levels did not always match the planned numbers required which at times put the safety of women and birthing people and babies at risk.
- Medical staff had not all completed mandatory training such as safeguarding training to the correct level.
- Midwives on the labour ward had not all completed training on how to evacuate the birthing pool in an emergency.
- Safety checks, such as CTG fresh eyes and MEOWS, were not always recorded to have been completed on women and birthing people in line with best practice. Further work was needed to improve compliance in this area.
- Whilst there was a bereavement suite available the location of this was on the labour ward which is not in line with best practice.
- Policies did not always reflect the most up to date and appropriate guidance available.
- Ligature assessments had been carried out and staff were aware of where emergency equipment was but the risk assessment needed reviewing.

Is the service safe?

Requires Improvement ↓

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all staff had completed mandatory training in line with trust targets.

Maternity

Medical staff overall compliance with training targets was 90% which met the trust target. Nursing and midwifery staff compliance with training targets was 92%, this also met the trust target of 90%. The service had a training guideline; it was in date, version controlled and next due for review in January 2026. The guideline included a training needs analysis which outlined all training required to be completed by maternity staff. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards and outlined how learning from incidents should be managed.

The service made sure that staff received multi-professional simulated obstetric emergency training (PROMPT). PROMPT training had been completed by 100% of consultants, 95% of registrars, 93% of midwives and 75% of midwifery support workers. The service told us the low numbers for midwifery support workers was due to a recent increase in recruitment to the role and further training was booked to increase the number of people attending this training.

The service provided training and competency-based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Nursing and midwifery staff compliance was 90% and medical staff compliance was 94%. Staff completed skills and drills training regularly. Records showed staff completed skills and drills training monthly on scenarios such as eclamptic seizure (a rare occurrence of seizures in those suffering with pre-eclampsia), baby abductions and abnormal CTGs. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Staff had completed adult life support training. For adult life support medical staff compliance was 84% and nursing and midwifery staff compliance was 80%. This meant that not all staff had training to provide lifesaving treatment to women and birthing people and this was below the trusts target of 90%. 86% of midwives had neonatal life support training, with 75% of community midwives having completed this training.

The service provided pool evacuation training to staff working in the co-located Calderdale Birth Centre and there were enough staff trained to evacuate women, birthing people, and babies from the birthing pool on the birth centre in an emergency. It was not clear from speaking to staff on the labour ward that all staff knew how to evacuate a birthing pool and the training evidence provided by the service did not evidence that staff on the labour ward had received training for pool evacuations. There was one birthing pool room on the labour ward and staff told us this was used. We found no evidence that women and birthing people had been harmed as a result.

The service had a team of specialist midwives across the hospital services including a practice development midwife who was also the lead midwife for monitoring fetal wellbeing. Their remit covered, monitoring of training compliance, conducting audits, supporting delivery of PROMPT training, and promoting and supporting professional and clinical development. They were involved in governance meetings within the service to understand areas of improvement needed and to provide feedback of training compliance.

Managers and the specialist midwife monitored mandatory training and alerted staff when they needed to update their training. Training was recognised as a key factor in the safety of the service, so steps were taken to prevent training being cancelled or delegates pulled due to staffing pressures. Additional training available to staff was advertised on a weekly newsletter which was sent to all staff and updates on compliance with training was provided at the governance meetings.

Safeguarding

Some staff groups had not received training on how to recognise and report abuse. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.

Maternity

Not all staff received training specific for their role on how to recognise and report abuse. Level 3 safeguarding training was provided to midwifery staff however this was not included for all medical staff which is not in line with national intercollegiate guidelines. The trust told us they only required consultants to complete level 3 safeguarding training and only consultant in sexual health had to complete the Safeguarding adults level 3 training. This meant that registrars and other medical professionals had not received the relevant safeguarding training as required.

Not all staff received safeguarding training at a level suitable for their role. Level 3 safeguarding children's training was completed by 92% of consultants and all trust grade doctors, this met the trust's target for safeguarding training which was 90%. Nursing and midwifery staff compliance was 83% for adults safeguarding and 66% for children's safeguarding (level 3). This did not meet the trust target of 90% and not in line with national guidance (Intercollegiate Document (2019). Support staff/unregistered nursing staff compliance with training targets was 86% for safeguarding adults, this did not meet the trust target and 93% for safeguarding children which did meet the trust target. The service had recently changed how they deliver safeguarding training which was split training across 3 modules including 1 face-to-face session; the aim was to make it more comprehensive and tailored to the needs of staff. Leaders told us this had impacted on their training compliance figures but training was booked to ensure staff received this training and improve compliance. The Adult Safeguarding Team also provided a 'Lunch and Learn' training session within wards and departments to further supplement the mandatory training, informed by recognised emerging themes, trends and gaps in knowledge which has been positively received.

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 (2010). 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 or complex situations and staff told us about a recent example where they had received support to ensure the safety of women and birthing people. The safeguarding team regularly attended the different units and staff told us they were visible, approachable, and supportive. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

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 conducted a tabletop, interactive session around what would happen if a baby was abducted within the 6 months before inspection. Security across the maternity service had improved since our last inspection however this remained on the risk register as a low risk.

Maternity

The service used serious case reviews from other areas to learn and improve their safeguarding practices and raise awareness. For example, following high profile safeguarding cases and lessons learnt, training and awareness had been raised around “the myth of invisible men and significant others”. The trust had looked at work to support the role of Fathers in the care of a newborn which led to funding being secured to introduce educational resources called “DadPad”. The DadPad is a guide developed with the NHS to support Dads in providing knowledge and practical skills needed.

Examples were shared evidence of pro-active support provided by midwives in identifying women and birthing people experiencing domestic violence. This resulted in multi-agency working to help these people escape their abuser.

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.

Cleaning checks were completed by both ward managers and matrons at different intervals. The service performed well for cleanliness on audits completed. The service audited the environmental cleanliness every month. We looked at audits for the last 3 months across the different areas of the service and found that the service performed well across all areas.

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. In the last year compliance was consistently above 95%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned equipment between uses and a sticker system in place made it was clear equipment was clean and ready for use.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe, staff were trained to use them and managed clinical waste well. However, the layout and design of the service was identified as an area for improvement.

The service acknowledged and were addressing issues with the design and layout of the environment. The service was spread across a large area and across multiple floors. The trust had approved structural changes to the layout to ensure a better flow and easier access between units. The current bereavement room was based on the labour ward and whilst consideration had been given to its location, in terms of impact of noise and reducing contact with others, its location did not meet department of health best practice guidance on maternity care facilities. The planned structural changes had not included relocating this facility. Fundraising work in the local community had raised money specifically for improving the bereavement room, however there were no current plans to implement any changes.

The maternity unit was fully secure with a monitored entry and exit system.

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

Staff carried out daily safety checks of specialist equipment. Records checked showed that emergency equipment and emergency trolleys used for adult and neonatal resuscitation were regularly checked and equipment was present and in date.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

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 was a dedicated sonographer located in the maternity assessment to take on the day referrals from both community and triage. However, the service had requesting funding for new scanning equipment that would reduce the risk of human error when measuring and tracking growth scans.

There was a portable ultrasound scanner, computerised cardiotocograph machines and observation monitoring equipment readily available.

Staff on the labour ward were not familiar with the location and use of pool evacuation nets where there was 1 birthing pool in use, we raised with the leaders in the service at the time of the inspection who told us they would ensure all staff were provided with an update.

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.

The service had completed a ligature risk assessment in all areas of the service; however, this had not been reviewed since completion in 2021. A training package was in place around ligature prevention and rescue and staff we spoke to could identify where the necessary equipment was located.

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 used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in detecting the seriously ill and deteriorating women and birthing people using the service. The MEOWS chart is used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any person whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016). Audit results showed that 60% of women had a MEOWS chart completed and 62% of MEOWs observations requiring escalation were escalated appropriately. The MEOWs observations were reviewed for 5 antenatal and 5 postnatal woman and birthing people each month between October 2022 and December 2022. Observations were consistently performed on women post caesarean section, but an audit of notes found that post spinal anaesthesia observations for any other procedure were not undertaken appropriately. There were no common themes for or trends

for failures in escalation. An action plan was put in place to refresh staff's knowledge on the current policy in place and for specific training to be implemented with further audits to be carried out in July-September 2023. We saw how the audit outcomes and guidance had been fed back to staff in the weekly newsletter. Records reviewed as part of the inspection were all completed and escalated appropriately.

Women and birthing people were triaged on arrival to the hospital when they were not attending for a planned birth. The service had implemented clear guidance to help midwives and medical staff determine the clinical urgency in which women and birthing people need to be seen. The service audited the use of the triage tool monthly. We looked at audits for the last 3 months and found that there had been noted improvements. The percentage of records with no recorded risk assessment ratings for women and birthing people attending triage fell from 27% to 8%. The number of women and birthing people waiting for over 30 minutes to be triaged had also reduced from 44% to 32%. The service was working towards all women being seen within 15 minutes. The service had recognised that improvements were needed in triage and had introduced a dedicated registrar Monday-Friday, 9am-5pm, at times when activity was highest. The actual midwifery staffing levels in the triage area did not always meet the planned staffing levels and staff told us this had the biggest impact on waiting times. Planned staffing levels in this area was currently 2 midwives which did not allow for a dedicated midwife to cover the telephone triage. The service was trying to allocate 3 midwifes to allow for this but this was not always possible due to staffing shortages.

The service was also working towards allocating a dedicated midwife to cover the triage telephone calls away from the main clinical area. However, this was not yet fully embedded, and staff were not always available to cover this role. Staff told us that managing the telephone calls at the reception area as well as triaging and assessing women impacted on the overall care and treatment provided to women and birthing people including the triage and assessment times. They also told us they felt under increased stress and pressure during these times. Staff told us they would benefit from a team of core staff in the triage area, but this was still under review by leaders in the service. Leaders told us this was still under discussion as they did not want to de-skill midwives by removing them from triage. Both these areas for improvement had been identified in an independent, external review of triage carried out in February 2023. In response the service had developed a working party and allocated a band 7 midwife to oversee triage and support in implementing the improvements needed.

The service demonstrated how training had been implemented to address timely transfers from the maternity assessment unit to theatre. This was carried out in a timely manner with staff after it was identified as an area for improvement at the weekly meeting reviewing incidents.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists monthly and fed the findings into the maternity forum where findings were shared with staff. There was 99.8% compliance with the tool.

During this inspection we reviewed the service's maternity quality dashboard. The dashboard included thresholds and regional indicators and provided target figures for monitoring purposes and as a benchmarking tool. The service used the dashboard template which was developed and supported by the local maternity and neonatal system (LMNS). The dashboard reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery), trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (preterm delivery) and public health information. The service had a service specific quality dashboard to maintain oversight of the entirety of the care provided to women. The dashboard showed that there was a high number of smokers at booking and delivery, and a higher number of women and birthing people booking after 13 weeks. However, these were not outliers in comparison to regional or national figures and both in-house and external smoking cessation pathways were in place. The variety of smoking pathways available were also audited for effectiveness.

Maternity

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

Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). CTG is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh-eyes" or “buddy” approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes audits from November 2022 to April 2023 and found that compliance was initially poor. Each month 10 records were reviewed, in November 2022 only 3 of the 10 records reviewed were compliant with the regular fresh eyes reviews, this gradually improved over the next 5 months but still had not gone above 8 out of 10 records being fully compliant.

Safety recommendations had been made by HSIB in relation to the CTG monitoring in reports shared from January and May 2023. Specifically, that CTG monitoring is commenced as soon as concerns are identified that action is taken recognise, escalate, and expedite the birth as soon as possible and that the recordings are of high quality or action is taken to address the quality of recordings. The trust had purchased and received 30 new CTG machines in January 2023 which addressed the issues with availability of machines and quality of the recordings.

Staff had the support of a perinatal mental health lead and a perinatal mental health midwife; staff knew who to contact out of hours if there was a concern. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns and how any information was recorded and accessed on the care records.

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

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

The service did not currently audit newborn risk assessments when babies were born using recognised tools such as newborn early warning trigger and track (NEWTT). The service had identified an increase in the number of neonatal deaths from 8 in 2021 to 18 in 2022. This prompted a more in-depth audit to be carried out which showed in 9 of these deaths, the cause of death was severe prematurity. The service provided assurances that all deaths were reviewed thoroughly to ensure the service had a good understanding of the circumstances surrounding each loss. However, it was not clear from the information provided how the trust was monitoring signs of a deteriorating baby and whether audits of such monitoring were completed.

The service provided transitional care for babies who required additional care, this allowed enhanced levels of care whilst remaining with the parent on the postnatal ward.

Staff completed risk assessments prior to discharging women and birthing people into the community making sure third-party organisations were informed of the discharge. The service had identified incidents where appointments had not been scheduled correctly with the community midwife particularly out of area and were looking to improve the technology in place to prevent such incidents.

Leaders monitored waiting times and made sure women and birthing people could access services in a timely manner when needed and received treatment within agreed timeframes and national targets. This was an area the service recognised needed to make further improvements and steps had been taken ensure appropriate staff cover was provided at all times.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned number of staff. We reviewed the planned versus actual staffing presented to the board for the month of August 2022. On average for August 2022 there were 49% occasions the actual staffing did not meet the planned numbers. This meant there was not always enough staff to care for women, birthing people and babies. We saw staff reported incidents appropriately in relation to staffing.

On the day of inspection there were 8 midwives instead of the planned 10 across the labour ward, plus 1 midwife allocated to answering triage call on the maternity assessment unit. In addition to the supernumerary labour ward coordinator there was also a band 7 midwife who had a helicopter view of staffing across the service. This was a role rotated amongst the band 7 specialist midwives Monday-Friday. We found that there was a responsive approach to the shortages with staff moving between units to ensure that women at higher risk were supported. We also saw how non-clinical staff stepped in to provide support and cover when midwives needed to support a birthing person.

Staff told us that at times it felt unsafe in the maternity assessment centre and staff would often work on their own or with 1 other midwife when ideally there should be 3 midwives in this area. Staff told us they felt that the labour ward was always prioritised over triage. Staff had reported this on the incident reporting system and to leaders and this was included on the risk register as a high risk. We saw that working party had been established to try and address the issues within the maternity assessment centre. Leaders told us how they were trying to ensure 3 midwives were working in this area rather than the 2 currently planned, however this was not always possible due to staff shortages.

We also found that the postnatal ward was short staffed by 1 midwife. This resulted in 1 midwife working alone caring for 7 women and birthing people at the time of the inspection, as well as supporting women attending the ward who were starting process of induction of labour, after which they would go home. The midwife working told us they felt this was safe and they were clear on the escalation plan should this change. They also told us they felt supported by the ward manager and matrons.

Some women and birthing people told us that care outside of the labour ward was not always person centred and dignified due to a lack of staff available to support and monitor them. For example, one person told us how the level of support provided on the post-natal ward was not sufficient and that support to bathe after labour was not provided. They also told us that observations on their baby was not as frequent as they were told it would be and discharge was

delayed due to staffing levels. Another person told us how they waited for long periods in the triage area and were monitored for longer than they were told they would be and felt "forgotten". They also told us they felt this was impacted by a shift change. However, we also reviewed a high number of positive comments and compliments which were shared on the service's social media pages about the care across all areas of the maternity service.

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 (2015)'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between December 2022 and May 2023 there were 90 red flag incidents, which related to delays in antenatal care due to high levels of acuity and delays to emergency caesarean c-sections. Weekly meetings were held and attended by a multi-disciplinary team in which all reported incidents including those related to staffing were discussed to ensure they were documented, graded, and managed appropriately. This included delays to induction of labour and delays to caesarean sections. The reviews analysed day of the week, time of day and whether escalation was appropriate at that time to on-call medical staff in line with the trust policy.

Women and birthing people received 1:1 care and the labour ward coordinator was supernumerary. The 1:1 care of women in labour and the supernumerary status of the labour ward coordinator were used as safe safety indicators which were shared at the monthly maternity quality committee meeting and the board. The labour coordinator role was consistently supernumerary 100% of the time for the past 3 months and they had oversight of staffing, acuity, and capacity on the labour ward. The 1:1 care for labouring women year to date was reported to be in place in 99% of cases.

Following an initial staffing review in November 2020 changes to staffing in maternity were made in line with recommendations from the Ockenden report. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service completed a staffing and acuity review in June 2023. It said the service did not have enough staff to meet the planned needs of women. There were plans in place to address the shortfall to provide safe care to women who used the service. This included the successful recruitment of 14 newly qualified midwives and 2 international recruits with a further 3 planned. This review recommended based on a decreased birth rate of 4313 a total of 174.63 WTE staff which includes 161.73 WTE midwives and 12.9 WTE non-clinical midwives. The total midwifery establishment including non-clinical in March 2023 was 149.64WTE, a shortfall of 24.99 WTE staff.

The staffing proposal shared with the chief nurse, reviewed the current skill mix options and proposed 10% of midwifery posts would become either maternity support workers or staff nurse positions. These posts would include maternity support workers working in community, on the transitional care pathways and staff nurses working on both the labour ward and postnatal ward. The birth rate plus report advised that non-clinical staff worked in postnatal care only, it wasn't clear from the proposal whether this would therefore be a move away from national best practice guidance.

The ward managers did not always have 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 the different clinical areas based on the presenting risk. Some staff told us this was at short notice and could at times leave other areas low on staff.

A recruitment and retention midwife was in post on a part time basis. This was alongside a clinical midwifery educator to support newly qualified midwives and a clinical midwifery support worker (MSW) educator to support newly qualified MSW's.

The service completed exit interviews with staff to try and retain staff. Workforce data collected between April 2022 and March 2023 showed that 23% of midwives left to take up jobs of the same grade in another trust, 20% left the midwifery

profession and 13% left for promotion. Sickness and maternity leave also accounted for other vacancies within the service. A recruitment and retention working party and strategy was established to support the retention and recruitment of midwives and the trust told us there was an active midwifery recruitment programme with a rolling advert as well as work with the LMNS.

The service used bank staff when needed and increased the pay offer as an incentive for staff to cover shifts when risk was high.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before working within maternity.

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. Appraisal Rates for 2022-23 were completed with 83% of midwives overall.

A practice development midwife worked part-time alongside their work as the fetal monitoring midwife to support the development of midwives.

The service was keen to offer developmental opportunities such as developmental labour ward coordinator and clinical manager posts to encourage succession planning. They had also appointed to several specialist roles from within, such as band 7 bereavement lead midwife, public health midwife and governance midwife roles. The service had recently approved funding for a midwifery apprentice for a midwifery support work and were looking to continue with this offer of support to further MSW's.

Medical staffing

The service did not always have enough medical staff to meet the demands of the service. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep women and birthing people and babies safe. The number of weekly consultant hours were less than the nationally recommendation based upon the number of babies born. However, the service told us they had recently had agreement to recruit more doctors within the Doctor trainee rotational programme. There were 2.6 WTE vacancies to meet the planned numbers of doctors needed.

The Ockenden Review 2020 recommendations state there should be a separate consultant rota for obstetrics and gynaecology medical staff. However, due to the current lack of consultants the service had not been able to create a separate rota. The service acknowledged the risk this presented to women and birthing people, and this was recorded on the risk register a case for additional funding for more consultants had been submitted but not yet received approval from the trust.

Shortage of consultants also had an impact on the scanning capacity in the service and cover for antenatal clinics. Doctors were stretched to ensure cover was provided across the service and this increased the risk of burnout and errors.

The service always had a consultant on call during evenings and weekends. However, due to the staffing pressures, medical staff did not take compensatory rest days following a busy on call shift. Whilst doctors acknowledged that in theory this could happen, they felt this was not normal practice due to the negative implications this had on meeting the needs of women and birthing people in the service. Rest facilities were not available at the time of inspection for the on-call consultants as these had been allocated to junior doctors in response to feedback from them. The service acknowledged this, and we saw this was discussed in governance meetings and they had sourced facilities which they were in the process of discussing with the consultants to make available.

Doctors told us they did not always have protected time to complete investigations which impacted on the timeliness of reports being completed.

Medical staff told us they were able to use locum doctors but that this rarely happened as shortfalls were often covered by existing staff or doctors on bank who are familiar with the service.

The service had a good skill mix of medical staff on most shifts however difficulties were presented when there was short notice sickness or there were high levels of acuity. We observed this on the second day of our inspection and as a result there was no doctor within the triage unit.

Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Junior doctors told us they were well supported with their training but that the rota was not always flexible to ensure protected or paid time for teaching. junior doctors felt there was an expectation for this to be done in their own time.

All medical staff we spoke to felt there was a positive working relationship between medical staff and midwives and there was an open culture that promoted the safety and care of women and birthing people.

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 on digital systems. The trust used electronic records across all areas of the service. We reviewed 10 sets of 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 electronically. Staff locked computers when not in use and security systems such as fingerprint recognition, were in place to access these records.

We saw recorded incidents in which care for women and birthing people had not been correctly recorded electronically to enable the community midwives to pick up postnatal care following discharge. No harm had occurred as women had communicated missed appointments with the maternity service who then acted, however, this was an area of risk especially for out of area women and birthing people.

Medicines

Maternity

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

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic records for medicines that needed to be administered during their admission. We reviewed 5 sets of medication records on the electronic system 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. The pharmacy team supported the service and regularly reviewed medicines prescribed. These checks were recorded in the records we checked.

Staff completed medicines records accurately and kept them up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

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. Medicines were in date and stored at the correct temperature. Where medication fridges were out of range, we saw that appropriate action had been taken and documented to mitigate the risk of compromising medicines. Staff checked controlled drug stocks daily.

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. However, learning and recommendations from incidents were not always embedded.

Staff knew what incidents to report and how to report them and there was a good reporting culture within the service. 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. We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly.

Leaders in the service met weekly to discuss incidents to ensure they were appropriately reported. graded and escalated as needed and to identify any immediate action required. Records were also checked electronically to pick up any concerns that had not been recorded as an incident. Actions were monitored to ensure they were allocated to the appropriate person and completed in a timely manner. There was a weekly meeting to discuss all new and on-going serious incident cases.

We reviewed 4 serious incidents and found staff had involved women and birthing people and their families in the investigations. In all investigations, managers shared duty of candour, reports are routinely shared with families. However, a staff member who was part of the PMRT team told us that PMRT investigation reports were only shared if requested by families.

Managers reviewed incidents taking into account the impact of health inequalities. We saw how specific audits had been carried out to review the impact of health inequalities on still births and neonatal deaths and how current and on-going work was already in place to try and mitigate risks identified, this included those related to health inequalities.

We found that serious incidents reviewed by the trust were not always robust in identifying concerns. Issues identified from an external body review carried out by the health safety investigation board (HSIB) had not been picked up by the trust. For example, in one case issues identified by HSIB around appropriate monitoring and quality of CTGs was not identified by the trust. Action however had already been taken to replace 30 CTG machines by the time the report was published, as there was a known issue with the quality and availability of CTG monitoring equipment which had been identified in previous serious incidents and HSIB reports. We also found that findings identified by HSIB had not been used to improve practice and the focus was solely on the safety recommendations made. In one case staff did not use the emergency crash call to alert medical staff as they did not want to alarm the mother which was against trust guidance. A concern was then identified 5 months later by the service when staff did not follow guidance in using the crash call to summon assistance. Neither incident had impacted the outcome, but learning should have been taken to mitigate potential future risk. However, we also found that the trust had identified issues which had not been identified and addressed as part of the HSIB investigation.

The service had a 'risk and governance' midwife who was responsible for sharing learning from incidents. Learning was shared with all staff in a one-page weekly newsletter, which staff spoke about positively in terms of accessibility and relevance of the content. The 'professional development midwife and fetal monitoring lead' also ensured that learning from incidents and audits were embedded in to training and updates. We saw how a near miss had been discussed at the weekly governance meeting and then training was provided to staff in the relevant areas of the service in the same day.

Staff reported serious incidents clearly and in line with trust policy. Referrals to external partners were also made appropriately to ensure an open transparent culture and appropriate external scrutiny.

Staff understood duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if things went wrong. Governance reports did not always explicitly evidence the involvement of women and birthing people and their families in investigations but did include evidence that duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at clinical governance meeting. We reviewed meeting minutes from the last 3 meetings and saw how leaders addressed areas for improvement with staff across disciplines and worked with other teams to improve outcomes. For example, a medication error was shared at the meeting and work was done with midwives and the pharmacy department to increase checks and awareness to prevent reoccurrence. This was then shared in the staff weekly newsletter for learning.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Quality improvement projects had been supported by senior leaders to review better systems and processes for the induction of labour with the aim of reduce delays and improving the outcome for women and birthing people.

Managers debriefed and supported staff both immediately after a serious incident and then again once staff had time to reflect and initial investigations had been completed to review good practice and areas for improvement. Staff told us they had the opportunity to talk about incident with their direct line managers and the person allocated to investigating the concern. Staff told us this felt supportive and not punitive.

Maternity

The service had no ‘never’ events on any wards.

Is the service well-led?

Good  

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

Leadership

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

The service was led by a director of midwifery, clinical director, and deputy director of operations. The triumvirate were supported through clear professional arrangements. The director of midwifery was line managed by the divisional director and the deputy director of operations and clinical director were line managed by the divisional director. The director of midwifery also worked closely with and reported to the chief nurse.

Attendance at weekly maternity governance meetings consisted of the patient safety and quality midwife, the obstetric lead for safety, the consultant of the week (where possible), the deputy head of midwifery, maternity ward matron, the matron for the community and the birth centre, and the labour ward and maternity ward managers. Incidents and activity across maternity were reviewed and discussed to look for themes, trends, learning and improvement. Incidents were then escalated to the Divisional orange panel in which incidents rated orange (indicating moderate risk) and above would be reviewed with investigations allocated and completed investigations shared for approval and/or further action.

Leaders 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. 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. We also saw how the chief nurse for the service held open-door drop-in sessions for staff to raise issues with them directly.

Leaders in the service completed a piece of work which looked back over the last 3 years at all the action plans, learning and changes that had been implemented to bring about positive change. The aim was to review if changes had been fully embedded and were now part of good practice within the service. The leadership team were passionate about the work they had done to drive improvement.

The service was supported by maternity safety champions and non-executive directors who regularly visited the unit. Following feedback from staff that they were not always aware who the safety champions were, the role and identity of the safety champions was better communicated to staff by way of the newsletter. The safety champions were clear about their role and responsibilities and were aware of the challenges faced by maternity services. They were also aware of the demographics of the community they served and the associated risks. The clinical safety champion and chief nurse had introduced an open-door maternity session every month to give staff an opportunity to provide feedback and share any concerns or areas of improvement.

Maternity

Senior leaders in maternity services met weekly. We looked at meeting minutes for the last 6 months. Issues such as training compliance, recruitment, incidents, staff well-being and strategic issues were discussed with actions allocated.

Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. We saw how midwives took positions in development roles for labour ward co-ordinators and clinical lead roles as part of succession planning. Midwives had also undertaken additional training to upskill them in areas such as sonography.

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.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and the strategy and actions taken had addressed these recommendations.

The service had a vision for what it wanted to achieve and a 1-year, 5-year and 10-year strategy to turn it into action, which was developed with relevant stakeholders. They had developed the vision and strategy in consultation with staff and the values of the service underpinned vision for the service. Staff could explain the vision and values and what it meant for women, birthing people and babies.

The vision and strategy focused on sustainability of services and aligned to local plans with a specific focus on safe care addressing health inequalities in the local population. The service also had a separate health inequalities strategy and plan.

The maternity service strategy was part of the overarching trust strategy and the nursing and midwifery strategy.

There was a process in place to measure progress annually with updates provided to staff. The strategy had also been condensed to a one-page overview to make this more accessible.

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.

Staff were overall positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff gave us examples of issues they had raised around the induction of labour process and how their well-being had impacted because of abuse from patients. As a result, a quality improvement piece of work was undertaken by midwives to look at improving the process and reducing delays faced by women and birthing people.

Maternity

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. Staff demonstrated a passion to improve the service to improve the experience for women and birthing people.

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 including the differences within the local population. The service had a health inequalities strategy with a working group established to drive improvements and initiatives. Outcomes for women and birthing people were monitored and data interrogated to identify when ethnicity or disadvantage affected treatment and outcomes. For example, the service set up a Task & Finish group to conduct a deep dive into why rates of stillbirth in some of the areas where women and birthing people lived were higher than others and whether there were modifiable risk factors linked to health inequalities that could be addressed. Findings from this were then shared with staff. Additional educational resources for women, birthing people and partners were made available to try and reduce some of these inequalities. For example, in partnership with a local college an English to Speakers of Other Languages (ESOL) for pregnancy antenatal classes were run. The aim was to improve patient awareness and experience of maternity services, to reduce health inequalities and improve pregnancy outcomes for women who do not speak English.

A neonatal death audit was also undertaken due to the increase in deaths in 2022. The audit highlighted that 61% (11/18) of mothers who had a neonatal death lived in the most deprived areas. The audit has been presented at the Maternity Health Equalities Workstream and further analysis is being undertaken.

Staff had also completed a cultural competency training package as part of the strategy with the impact and effectiveness measured as part of a staff survey following completion of the training.

Several initiatives were also in place to support a diverse and inclusive workforce such as developing a Cultural Awareness digital education booklet, a suite of financial wellbeing support for colleagues and an international nurse's support event was held.

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 women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The service received 6 complaints in the 3 months before the inspection. Themes included Staff - Values & Behaviors, Patient Care and Clinical treatment. Out of the 6 complaints 1 was closed, 2 were overdue at the time of the data being shared and 3 were still within the allocated timeframes. Feedback was shared with staff to improve the service once investigations were completed. Complaints was a fixed item agenda on the Maternity Safety Champions Meeting and Perinatal Quality Surveillance Meeting held monthly.

The trust told us how the progress of open complaints was discussed weekly with the trust's complaints team to offer further scrutiny and challenge.

The service provided an overview of the main themes from the most recent staff survey in 2022 which was also compared to findings in 2021. In 2021 there had been a decline in the scores for the women's directorate and so a focus

piece of work took place to look at the 'One Culture of Care Charter' which aimed to establish a set of agreed upon values and behaviours with staff. While the service acknowledged there was further work to do, improvements were seen in the 2022 survey; in particular for the questions around learning, engagement and morale. Participation with the survey had also improved in 2022 compared to 2021.

The "People Promise" scores improved overall, the element with the biggest improvement was "We are always learning." Although this element had the biggest improvement, it was still the lowest scoring of the 8 elements. The highest scoring element was "We are compassionate and inclusive."

We also reviewed the free text submitted by staff as part of the maternity survey 2022. There were 55 responses, the main themes were around unsafe staffing levels, poor managerial support, lack of flexibility with shifts impacting on well-being and a lack of appropriate equipment and facilities. The service did not send us analysis of these comments or actions plans around how they had addressed these comments. There was also reference to a poor culture and favouritism in relation to certain staff by managers which some staff felt impacted on their progression within the trust.

A monthly safety champions meeting was attended by the executive and non-executive safety champions, maternity and neonatal safety champions, the ICB and LMNS. Standing items on the agenda included audits, exception reports, outcomes from external investigations (HSIB), a review of the risk register and complaints and compliments.

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 and managers were clear on the links to trust wide groups and committees to escalate risks and issues.

A maternity forum meeting was held monthly to support the Patient Safety and Quality Board by managing a program of performance monitoring and continuous improvement, to provide assurance that the essential levels of quality and safety were being met. A 6 monthly assurance report was shared with the Women's Directorate Governance meeting.

Monthly Women's directorate governance meetings were held and chaired by the Clinical Director. The deputy divisional director/general manager, senior finance officer, deputy head of midwifery and maternity and gynecology matrons also attended.

Relevant information was escalated to the Trust Divisional board which was chaired by the divisional director.

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

Maternity

Senior leaders in maternity services met weekly. We looked at meeting minutes for the last 6 months. Issues such as training compliance, recruitment, incidents, staff well-being and strategic issues were discussed with actions allocated.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board.

Maternity Clinical governance meetings were held weekly. We looked at meeting minutes for the last 3 months. Activity across the maternity service was discussed which included number of births, births before arrival, incidents, delays, whether processes were followed, and any action required to address shortfalls. We found that staffing levels had impacted on delays to induction of labour, but that individual risk was reviewed to ensure women and birthing people were prioritised appropriately. We saw that doctors and medical staff had not always recorded their decisions in records and this was fed back to individuals.

The maternity and neonatal safety oversight report was presented monthly. We looked at meeting minutes for the last 3 months which provided an update on transformations programs, compliance with national reporting and safety reporting to HSIB, updates on staffing and audits, activity and external reports in neonates. Discussions and further audits were carried out where there were outliers in data collected. For example, there was an increase in shoulder Dystocia and so an audit was carried out to identify any trends and patterns to account for the increase. Findings were presented but there were no trends or patterns identified.

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 in the form of the weekly newsletters sent out by the governance midwife.

Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. We found that all policies were up to date, however the references did not always reflect the most up to date guidance and best practice available. We raised this with leaders who told us they would address this.

Managers and staff carried out a programme of repeated local audits to check improvement over time and ensure compliance with national guidance. Additional audits were requested following an incident, changes to practice or due to changes on the maternity dashboard. For example, when there was an increase from one month to the next in stillbirth rates and shoulder dystocia additional audits were conducted. Audits were also carried out to review effectiveness of changes to practice around mechanical induction of labour. 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 in meetings and weekly newsletters.

There was a clear schedule of audits for the year set out which looked at both national priorities and local priorities with staff allocated to complete the audits, timeframes and the forum or meeting that the findings would be presented to.

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.

The service participated in relevant national clinical audits. 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.

Maternity

Leaders had 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. However, the service did not currently audit new-born risk assessments when babies were born using recognised tools such as new-born early warning trigger and track (NEWTT). Despite a deep dive in to increase number of neonatal deaths being carried out this was not identified as an area for improvement.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

The service had an escalation policy to proactively manage activity and acuity within maternity and across the trust. They followed a standard escalation policy across the local area. The service had not deemed it necessary in the past 12 months to divert services or close the unit. The trust had however taken the decision to close the stand-alone Huddersfield birthing centre and keep the co-located birth centre at Calderdale open. This allowed a more responsive model to women and birthing people's needs at a time when there are national and local midwifery staffing pressures. The change in how women were supported had led to an increase in births from 3 births in April 2023 to 40 births in May 2023.

The service had a risk register with 21 risks listed. We reviewed the risk register and saw 2 very high risks, 4 high risks, 9 moderate risks and 6 low risks. There was evidence of mitigation and controls in place with regular reviews and discussion. We saw evidence of some risks reducing over time. There was a clear owner assigned to each risk with an executive director also allocated for oversite. Target dates were in place and the risk register was clear and easy to understand. The main risks related to workforce and the knock-on effects as a result of staffing shortages. For example, workforce was listed at a high risk and delays to induction of labour, inability to adequately staff the maternity assessment unit and insufficient scanning capacity were all listed as a high risk which were linked to workforce.

The trust had an Incident Reporting, Management, and Investigation Group Policy which showed the trust process for reporting and managing incidents included the grading and assurance process, escalation processes and investigation process. When we reviewed incidents and meeting minutes, we saw the service followed the trust wide policy and this was well embedded.

Where there was a critical incident within maternity ‘hot and cold debriefs’ with staff would be carried out. A standard operating procedure was in place to provide guidance on how, where and when these should be conducted. ‘Hot de-briefs’ were carried out immediately after a critical incident had been stabilised and ‘cold debriefs’ were to take place within 2 weeks. Debriefs were recorded using the incident reporting system and we saw evidence that these had been carried out following a serious incident within maternity with learning taken to improve practice in the future.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with 9 out of 10 safety initiatives. We saw they had provided sufficient evidence of their compliance to the trust board in January 2023. The trust had an action plan to meet the 1 safety initiative they were not compliant with which was around CO2 monitoring. This was subsequently achieved, and the Trust submitted compliance with all 10 safety actions.

The service provided up to data to the national MBRRACE -UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) survey. We looked at actions from the survey and saw the information was

presented to the LMNS (Local Maternity and Neonatal Systems) board in June 2023. They identified the complexities of the cases dealt with at the service for a level 2 local neonatal unit (This is typically for babies who need a higher level of medical and nursing support for babies born between 27 and 31 weeks). The findings were all within the group averages, but the service had identified upward trends and were looking to address these.

The service had a peer review around the model used for the triage or maternity assessment unit in February 2022. From the review we saw that there were positive findings in relation to the engagement and training with the implementation of a new national model and the commitment from leaders to further improve the implementation of the model. Areas for improvement included improving staff cover for the telephone triage, a dedicated staff team and lead to work within the triage area and improving the recording of data on the electronic system to provide more accurate data. At the time of inspection, we found that progress had started to action the recommendations, but further work was still required.

The service complied with all 5 of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care. We saw how audits had taken into account health inequalities for the local population.

We reviewed the trust's compliance with the perinatal clinical quality surveillance model and found the trust was compliant. The board were well cited on the maternity service, challenges faced, findings from audits and ongoing projects of work and information shared with the LMNS.

The service had an Ockenden assurance visit in June 2022 to assess compliance with the 7 immediate and essential actions from the interim Ockenden report 2020. The visit findings confirmed that all immediate and essential actions were met and included 10 recommendations for the trust to consider making further improvements. The service shared actions taken to meet these recommendations and work that was still on-going.

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 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 across the region for internal benchmarking and comparison.

The service had digital care records across maternity which were well embedded and understood by staff. Staff had a good understanding of how to use the systems and the service continued to improve systems where issues were identified or could be improved on.

The service had an electronic patient records specialist midwife who took a lead on the digital strategy within midwifery.

The service launched “My Pregnancy Notes” which was a “single point of access” patient interface to enable women and birthing people to make online bookings for pregnancy care and access to maternity notes.

The systems and data collection allowed for reports to be generated for auditing purposes and we saw how information on demographics and ethnicity for women and birthing people had been used to look at health inequalities.

The information systems were integrated and secure and staff used fingerprint recognition to access computers quickly and securely**.**

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 well with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP told us they felt heard, valued and the benefits of their role and contributions recognised.

Maternity Voices Partnership engagement meetings were scheduled monthly. There was a mix of focus groups, walk arounds of the service and listening events scheduled for the next 12 months. Meetings covered service user voice and experience, current workstreams, co-production, future plans and general updates and learning. We looked at minutes and action plans from the most recent meetings and saw there was a clear direction of work to improve the way service user voice was heard and increasing the voice and involvement of those at greater risk due to health inequalities. The MVP and service recognised that those women and birthing people at greater risk due to health inequalities were also the hardest to reach to obtain feedback and so feedback gathering through Discovery Interviews had been introduced both in the service and in the community. The findings of which were presented to the trust and action plans formed. Efforts had also been made to establish connections with several community groups and resources. A Gap Analysis of the CHFT Maternity Services website was completed and the Chair acted as part of the visiting team in the June 2022 Ockenden Assurance visit.

A patient experience group helped the maternity service to improve the service by capturing women and birthing peoples experience. As a result of the feedback a “you said, we did” report was shared. This included improving the information and resources available around feeding and tongue tie following a complaint. Feedback on the usability of the family and friends test also led to improvement in the layout and information collected on the cards.

The maternity service received 37 posts over a 3-month period of positive feedback and compliments via their social media page which was shared with staff.

We saw how feedback around breast feeding and tongue tie was raised by the MVP following feedback obtained at a discovery meeting. The service then took action to feed this back to staff in the weekly newsletters and to the NIPE midwife.

Both the service and the MVP were keen to further improve the involvement of the MVP in co-production and plans were in place for the MVP to be part of the complaints process and attend more maternity meetings. The MVP told us about how they were attending a community centre to meet with, harder to reach women and birthing people from ethnic minority backgrounds. This was being supported by a bilingual member midwife who would act as a translator to reduce communication barriers. The MVP did not have access at the time of the inspection to interpreter services but had raised this with the trust and was awaiting feedback.

Maternity

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity and deprivation based on postcode. The service made the decision to stop telephone consultations with women and birthing people where English was not their first language as it was acknowledged the difficulties with accessing effective interpreting services over the phone.

Leaders understood the needs of the local population, which was both rural and urban, both of which presented with individual challenges. They acknowledge the disparity between the local areas of Huddersfield and Calderdale and used audits to evidence the impact on women and birthing people. A vitamin D / Healthy Start Scheme was being promoted by Midwifery teams to increase uptake of Vitamin D and access to healthy food 'vouchers' for pregnant women and new mothers on very low incomes to spend on veg, fruit and milk.

They were aware of the ethnicity of population they served and how women and birthing people who were black or of an ethnic minority were more likely to experience poor outcomes. This was made clear within polices, meetings and findings from audits so it remained a focus.

Deep dives were conducted which had a specific focus on health inequalities. The service had recently, alongside the local college, conducted a pilot of English as a Second Language pregnancy antenatal classes, and this was proposed to continue. The service had improved included welcome signs produced in top 10 local first languages and there was mapping of multi-lingual resources available.

They had also carried out a staff survey on cultural competence with maternity staff and piloted rollout of a cultural competence training package. At the time of the inspection these results were not available.

The service held regular engagement sessions with staff. We saw that communication on updates took a range of formats across maternity, there was a regular weekly newsletter and emails shared with updates and the service had also held open days with existing maternity staff to share updated and seek feedback on issues. We also saw a schedule for staff meetings for maternity support workers, the birth centre (which included skills and drills sessions) and band 7 midwives.

An engagement session with community midwives for the Huddersfield and Calderdale areas had led to changes in practice around rotas, on-call and additional admin/non-midwifery support provided. This had positively impacted on workload and morale.

We saw that staff raised concerns at the open day about staff ability to raise concerns with the senior leadership team and a proposal was made to introduce staff representatives, this was on-going at the time of the inspection. The service was also investing in digital platform to support staff engagement.

The director and deputy director of midwifery also took part in listening events with student nurses and the university to ensure student midwives are heard and improvement where possible to their learning experience are made.

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.

Maternity

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. A quality improvement meeting to ensure oversight of ongoing quality improvement projects and actions was established in May 2023. Whilst there wasn't a quality improvement specialist midwife there was an overall commitment from the service to drive improvement which was part of the Journey 2 Outstanding program.

The introduction of a midwife sonographer clinic within maternity assessment centre in 2020 led to significant increases of women being scanned on the same day as the referral, this increased from 21% (2019) to 41% (2020) and the longest delay reduced from 11 days to 4 days.

The service showed innovation around the workforce and learning from other initiatives. For example, a Maternity Support Worker Clinical Educator had been introduced to develop the role of the MSW and provide support and recognition for the work they did. This was alongside the already established midwifery clinical educator role. Support for MSW included ensuring sufficient and effective training was available with assessment of competency requirements; with the aim of upskilling MSWs from band 2 to band 3. One MSW had recently enrolled on the midwifery apprenticeship university course funded by the Trust.

The service had been reviewing the workforce to use non-midwifery staff wherever possible to reduce the pressure on midwife's workload. The service was also using registered nurses within maternity and feedback from midwives was that this was working well with the skill sets of midwives and nurses complimenting each other.

The service introduced a Maternity Health Adviser to provide in-house stop smoking advice from October 2022 as the service found there was a poor uptake of generic stop smoking services by women and birthing people. In the first 6 months 149 out of 175 women and birthing people offered the service accepted it. The Maternity health advisor also provided more holistic advice on healthy eating, vitamins, and exercise in pregnancy.

The service collaborated with regional universities and charities to support research studies including participation in a smoking in pregnancy research which was undertaken and published.

The service ran a breast milk donation bank which was pasteurised in service with a pasteuriser recently being purchased. This was used not only for babies requiring this at Calderdale Royal Hospital but also as a source of income for the service.

The manager of the birth centre told us about the work carried out to improve the overall experience of the birthing person and parents of surrogate pregnancies. This included ensuring that parents were able to be present at the birth both antenatally and postnatally and there was an increased awareness amongst staff around the process.

The service also started a rainbow clinic in May 2021, this was designed to support women and birthing people who had suffered previous baby losses either due to miscarriage, stillbirth, or a neonatal death or where to the pregnancy had to be terminated due to medical complications. The clinic was run by a consultant and the bereavement midwife, and the focus was providing additional emotional, psychological, and clinical support to women and birthing people. This included additional assurance scans from 8-9 weeks.

We saw that there were on-going projects and proposals to further improve the service which included a business case to purchase more ultrasound equipment which would reduce the risk of human error and future reviews of elective caesarean sections.

The service had adapted leaflets and the language used to be more inclusive of LGBTQ+ couples and communities.

Maternity

Outstanding practice

We found the following outstanding practice:

A breast milk donation bank was run by the service, this was both a resource to supply breast milk to pre-term and in need babies within the service and a source of income.

A Rainbow bereavement clinic was run by a midwife and consultant obstetrician for women and birthing people who had a non-viable pregnancy or had experienced a previous baby loss. The aim of this clinic was to provide a greater level of psychological and clinical support.

Surrogacy work- the service had introduced additional clinics and support for women and birthing people who were having a surrogacy pregnancy. This included separate appointments for both the parents and the surrogate and joint appointments depending on preferences. Also, the practicalities of the birth plan as well as visiting both during labour and postnatally had been agreed on an individual basis.

Areas for improvement

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

Action the trust MUST take to improve:

- The service must ensure all staff are up to date with all relevant training, such as training around the emergency evacuation of the birthing pools on the labour ward for midwifery staff and safeguarding level 3 training for all medical staff. Regulation 12(1)(2)(c)
- The service must ensure there are at all times sufficient numbers of suitably qualified staff to meet the needs of women, birthing people and babies across the maternity service. Regulation 18 (1)

Action the trust SHOULD take to improve:

Location/core service

- The service should ensure that they continue to monitor and drive improvement around compliance with documentation such as CTG fresh eyes and MEOWS. Regulation 12 (2)(b).
- The service should consider the location of the bereavement room as part of planned reconfiguration works in line with best practice guidance and the feedback and fundraising efforts of the local community.
- The service should consider the regular reviews of ligature risk assessments across the service.
- The service should continue to improve on the appraisal rates for all staff.
- The service should continue to develop systems to ensure policies reflect current evidence-based best practice.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 5 other CQC inspectors, 2 specialist midwifery advisors and an obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.