Airedale NHS Foundation Trust

Airedale General Hospital

Inspection report

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Date of inspection visit: 06 December 2022
Date of publication: N/A (DRAFT)

Ratings

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

Our findings

Overall summary of services at Airedale General Hospital

Requires Improvement 

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

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

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

We did not rate this hospital at this inspection. The previous rating of requires improvement remains.

How we carried out the inspection

We visited all areas of the unit including the antenatal clinic, antenatal and post-natal ward, maternity assessment centre, labour ward and theatres; we spoke with 23 staff members. We reviewed the environment, and maternity policies while on site as well as reviewing 12 patient care records and 4 medication records. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 22 pieces of feedback and spoke with 7 women on the day of our inspection.

The trust provided maternity services at hospital and local community services and 1781 babies were born in the trust during 2021.

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

Maternity

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always have enough nursing staff to care for women and keep them safe. The service provided mandatory training in key skills, but not all staff had completed it.The service was unable to evidence training figures, including levels of appropriate safeguarding adults training or competency checks in medicines management. There were gaps in sharing safeguarding information during handovers. Staff did not always receive regular appraisals.
- The maternity assessment centre had no clear system in place to prioritise and risk assess patients, fresh eyes was not always completed in line with guidelines, there was no clear cleaning checklist, and the environment was not compliant with infection prevention and control standards.
- Policies and documentation were not always kept up to date, and audits were not always completed in line with trust targets. Action plans were not always completed or updated in a timely way.

However:

- Staff had training in key specialist skills. Staff worked well together for the benefit of women and understood how to protect women from abuse. The service generally controlled infection risk well. Staff assessed risks to women in most areas, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. The service had a vision and strategy which was developing. Managers monitored the effectiveness of the service. Staff felt respected, supported, and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged with women through local systems to plan and manage services. All staff were committed to improving services continually.

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, but not all staff had completed it. However, staff completed maternity specific training, and there was a training needs analysis in place.

Staff were not up-to-date with their mandatory training. Records showed that 79% of midwifery and medical staff had completed the required mandatory training courses against a trust target of 90%. Compliance was low in modules including basic life support with overall compliance of 55% and manual handling for people with overall compliance of 60%. Overall, midwifery staff met the 90% target in 3 out of 14 modules and medical staff met the target in 1 out of 14 modules.

Maternity

We asked the trust to provide compliance rates for medicines management training, however this was not provided, and we were not assured staff were up to date.

There was a rolling programme of PRactical Obstetric Multi-Professional Training (PROMPT), this was monitored by the practice development midwife and non-attendance was escalated to managers. PROMPT training was multidisciplinary and informed by learning from incidents, both internally and that occurred in the Local Maternity and Neonatal System (LMNS). The trust did not provide staff training figures for PROMPT.

The service had a plan in place for training in 2023 which was led by the practice development midwives. They were responsible for monitoring and managing staff training schedules. We reviewed the annual midwifery mandatory update day schedule for 2023 which included a range of topics, including a session in response to feedback from women and birthing people who used the service.

Staff completed maternity specific training, including newborn resuscitation training. The trust target was 90%; midwifery staff compliance was 96%, which included community midwives. The trust provided basic life support training to staff; 83% of medical staff and 53% of midwifery staff had completed the training which did not meet the trust target of 90%. This meant staff had not always received up to date life support 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 for fetal monitoring training was 92% and obstetric doctors' compliance was 100%; both staff groups met the trust target of 90%. For CTG competency assessments midwife compliance was 93% and medical staff compliance was 92%. Overall compliance was 93% which was above the trust target.

The service provided pool evacuation training to staff. Compliance for midwives and midwife support workers was 88%.

Consultants allocated weekly training sessions based on the needs of their current pool of medical trainees to provide tailored training and support to their needs.

The service provided live skills and drills training most of the time, which was overseen by the professional development midwife. Staff practiced simulated obstetric emergencies in multidisciplinary (MDT) teams in line with national guidance. The service had a system to monitor attendance when live skills and drills occurred with an aim to capture all staff throughout the year. During the inspection, staff told us skills and drills was facilitated monthly, and there had recently been a 'massive obstetric haemorrhage drill' which involved the whole MDT. However, due to staffing issues, skills and drills had not always been delivered in the months up to the inspection.

Managers monitored individual training requirements and alerted staff when they needed to update their training. The service had a training needs analysis policy for midwives, health care support workers, medical staff, and managers; it was version controlled and due for review in August 2025 and included a training needs analysis which outlined required training for staff in maternity services.

Safeguarding

Maternity

We did not see evidence of safeguarding adults training in line with national guidelines. Not all staff accessed electronic systems to check identified safeguarding concerns, and safeguarding information was not always handed over. However, most staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse in children and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse in children. We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training, the content was changed annually to reflect different learning topics, and the training included reflections on practice.

Level 3 safeguarding children training was provided to staff in line with national intercollegiate guidelines. The trust target for training was 90%. Medical staff's overall compliance with safeguarding training was 85% and midwifery staff compliance was 86%. This did not meet the trusts own target.

We asked for Safeguarding adults' level 3 training figures, however, these were not provided, so we were unable to determine if staff were trained in line with national intercollegiate guidelines.

Most staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them, however systems and processes to handover information were not robust.

We observed safeguarding information had not been discussed or documented during handover on labour ward; staff told us this was because the electronic system flag had not been checked. A safeguarding flag could be added if required to the electronic patient record system. We found patient records were electronic for antenatal and postnatal care; for intrapartum care, paper records were used. Staff could not clearly describe the process for checking safeguarding information on electronic records which meant safeguarding flags could be missed. We found there was a reliance on staff finding out key information at handovers, but we did not see that handovers reflected safeguarding concerns. We escalated this to the trust during the inspection and they told us they would review the process.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The lead safeguarding midwife monitored safeguarding referrals and concerns raised by staff and described thematic work they had undertaken to make sure people who used the service were safe. They told us they had developed good relationships with ward level staff and social care partners.

Staff knew how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Service leaders were aware of the diversity of their population and described actions they planned to address health inequalities in their area, including representation in the local health system. Mandatory training for staff included a module on equality and diversity which 88% of staff had completed. Staff followed safe procedures for children visiting the ward. Wards were locked and accessed by intercom and the service had procedures in place for visitors.

Staff followed the baby abduction policy and undertook baby abduction drills. We reviewed the baby abduction policy and saw it was in date and there was a system in place to identify babies on the wards.

Cleanliness, infection control and hygiene

Maternity

The service did not always control infection risk well. Staff used equipment and control measures to protect women, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were generally clean and had suitable furnishings which were clean and well-maintained. However, the Maternity Assessment Centre (MAC) had a carpeted floor in the main waiting area this was not in accordance with Health Building Note (HBN) 00-10 Part A Flooring (2013); this was an infection risk given that patients waited in this area and the carpet could not be wiped clean.

The service generally performed well for cleanliness. The service audited cleaning checks every month. We looked at audits for ward 21 in the 3 months prior to our inspection and found compliance was between 97% and 98%. There was evidence of re-checking an area or item if they were not compliant. We did not receive evidence of assurance for other areas of the service.

Cleaning records were up-to-date and demonstrated that most areas were cleaned regularly. However, there was no cleaning checklist in place on the maternity assessment centre (MAC). We spoke to domestic staff on duty who cleaned the area daily and they told us there was no system for recording what areas had been cleaned, or for recording sink flushes.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand hygiene showed between August and October 2022 on ward 21 compliance was 100%. However, compliance on labour ward was 90% in August, 95% in September and no data was submitted in October.

We reviewed the quarterly nursing high impact interventions report for August to October 2022 which reported on observations against set standards when observing staff undertaking peripheral intravenous cannula insertion and ongoing care and urinary catheter insertion and ongoing care. This was a trust wide audit and the wards completed up to 10 observations per month for each area. The observations different key standards depending on the intervention, including hand hygiene, personal protective equipment (PPE) and access. Labour ward were 100% compliant for peripheral intravenous cannula insertion, and 95% compliant for urinary catheter insertion. Ward 21 was 73 % compliant for ongoing care of peripheral intravenous cannula insertion and 100% compliant for urinary catheter ongoing care.

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

The service had processes to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit for labour ward which showed 88% compliance in December 2022, however only 3 in 10 areas had been completed because the auditor was unable to observe the remaining 7 items.

Environment and equipment

The design, maintenance and use of facilities, premises, and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all equipment was appropriately located and secured.

Women could reach call bells and staff responded quickly when called; 6 out of 7 patients we spoke with told us their call bells were responded to quickly.

Staff carried out daily safety checks of specialist equipment. We checked emergency trolleys and grab bags and found they had been checked and stocked appropriately.

Maternity

The service had suitable facilities to meet the needs of women's families, including bereavement facilities. However, we found two rooms on the labour ward had a shower situated inside the birthing room; there was limited ways to provide privacy and dignity for patients in these rooms.

The service mostly had enough suitable equipment to help them to safely care for women and babies. However, on labour ward the waterproof CTG machine in the birthing pool room was out of order which meant staff could not offer continuous monitoring for women who required it during pool births.

The net for the recovery of a patient in an emergency using the birthing pool was situated on the opposite side of the department to the pools and was not accessible in a timely way in an emergency. We raised this concern with the trust, and they told us they had moved the net and were purchasing a second to ensure they were accessible in a timely way for both birthing pools.

We also found there was a grab bag in the main labour ward corridor for use in an emergency when a baby was likely to be born before arriving at the department, however the grab bag was balanced on a shelf and not secured; there was risk it could be moved or go missing.

Staff disposed of clinical waste safely and in line with guidance.

We checked stock across the service and found most was in date and there were systems in place to rotate and control use by dates, however we found blood bottles in the Maternity Assessment Centre that were passed their use by date. We escalated this during the inspection and staff removed the out-of-date bottles.

Assessing and responding to patient risk

The Maternity Assessment Centre had no clear system in place to prioritise and risk assess patients. Fresh eyes was not always completed in line with guidelines.

However, staff generally completed and updated risk assessments for each woman and took action to remove or minimise risks in most areas. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. The MEOWS chart was 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 women 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).

The service did not monitor staff compliance to ensure safe completion of MEOWs charts, this meant the service could not be assured that staff had accurate oversight of the deteriorating patient. We raised this with the service who told us that they were implementing a quality improvement project to move MEOWS to the electronic patient record. Matrons completed a monthly audit which included checking the calculation, escalation, and response of MEOWS observations, however, this audit did not identify how many records were checked, and we only saw evidence of this audit on ward 21.

Maternity

Staff used 2 different types of MEOWs charts to plot women's wellbeing during labour. This was a risk because there were two different systems in place in different areas of the same pathway and there was potential for confusion and misinterpretation. We told the trust about this concern after the inspection, and they confirmed the paperwork in theatres was out of date; the trust told us this was removed to mitigate the risk of use.

Staff did not always use a 'fresh eyes' approach to review Cardiotocography (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. Staff told us fresh eyes was used routinely, and they could describe the process. We looked at the fetal monitoring audits for July, August, and September 2022; 10 records were checked each month. The audit checks included compliance with fresh eyes, time between fresh eyes, staff signatures, and overall compliance. Overall compliance was 50% in July, 40% in August and 60% in September. Across all three months, fresh eyes compliance was in line with guidance 53% of the time. We reviewed governance meeting minutes for the last three months at the reporting group for the audit, but we did not see any documented evidence the audit results were discussed, or actions were being taken to address the low compliance.

The service undertook quality improvement work to improve compliance in fetal monitoring and provided updated figures which demonstrated ongoing improvement in between December 2022 and March 2023, with compliance improving to 90%. The improvements were monitored through the service's Women's Service Forum.

Staff in theatres completed the World Health Organisation (WHO) Surgical Safety Checklist, which is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. WHO checklist audits were completed by the surgical division and the trust had a rolling audit programme in place. We looked at the most recent audit for December 2022 and saw the audit addressed the appropriate areas, and included commentary and learning. There was no reference to WHO checklists in the 3 months of governance minutes we reviewed in maternity services. It was unclear how oversight of surgical safety checklists was maintained, and results shared with staff and leaders in maternity services. During the inspection, we observed the completion of WHO checklists and saw the necessary checks were completed appropriately. Staff appeared to work well together to ensure the safety and comfort of women.

Staff had access to maternity specific sepsis policies and guidelines. We reviewed the "Care of the critically ill pregnant or postnatal woman" policy which had a section on sepsis and sepsis management. The policy was passed its review date of June 2022 and was being updated and ratified at the time of the inspection.

Staff used a RAG rated attendance criteria chart for the maternity assessment centre (MAC) or labour ward (outside MAC opening hours). The categories were: Referral to GP or community Midwife, MAC planned attendance with allocated time slot, MAC planned attendance as soon as possible for assessment and Immediate admission to labour ward or emergency department. The criteria were available in the MAC. However, the triage tool did not give target time scales for patients to be reviewed by medical staff. Staff told us there was no process or guidelines to prioritise women and pregnant people, they used their clinical judgement. This was a risk as there was no formal process to ensure women and birthing people were seen, risk assessed and treated in a timely way.

Managers did not monitor waiting times to make sure women could access emergency services when needed and received treatment. Staff recorded time of arrival, time seen, and time left, but did not know about any timed targets for triage or different levels of risk. The time a call to the MAC was taken was not recorded in the same place, so it was unclear how the service monitored the time to be seen from time of telephone call. We reviewed 4 sets of patient records for patients, and none had a recorded risk assessment or prioritisation score.

Maternity

Midwifery support workers told us they booked appointments for women and birthing people with symptoms they were aware of that midwives would offer appointments for, for example reduced fetal movements.

This was not in line with guidance, or the scope of practice of the role and support staff did not have specific training on MAC triage and prioritisation.

Staff told us work was ongoing around triage, risk assessment and escalation and there had been an initial audit completed. At the time of our inspection, findings were planned to be discussed in the local governance meeting to agree next steps. The service had not yet embedded a monitoring structure, and we were not assured that there was oversight of patient prioritisation and waiting times.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed antenatal risk assessments to inform care pathways for women and pregnant people presenting at the beginning of their pregnancy.

Staff knew about and dealt with any specific risk issues. We reviewed 12 sets of patient records and saw routine risk assessments were completed in a timely way in patient records spanning the patient journey.

Shift changes and handovers did not always include all necessary key information to keep women and babies safe. Staff handed over care of patients between shifts using a systematic and undisturbed format. However, we saw an example of missed opportunities to share safeguarding information during the inspection. We observed the midwifery handover on ward 21 and the medical handover on labour ward. Ward 21 used the SBAR method (situation, background, assessment, recommendation).

Medical staff on labour ward did not follow a structured handover process. We observed a handover and saw 13 staff members in attendance, no introductions were made, roles and responsibilities were not clear, outcomes of the handover were not clear, and we heard staff asking who was leading the round. We asked the trust to provide audits of handovers; on the audit plan that doctors' handovers were an ongoing monthly audit which commenced in July 2021, however, the trust did not provide evidence of the audit, outcomes, or related action plans. We reviewed governance meeting minutes for the last three months at the reporting group for the audit, but we did not see any documented evidence that audits were reviewed.

The service used a maternity dashboard. 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.

The service monitored the number of babies born before arrival as "unplanned home births" through their monthly dashboard.

The Newborn and Infant Physical Examination (NIPE) screening programme which screens babies for specific conditions within 72 hours of birth was provided to babies who were born at the hospital; staff told us this was completed, however, there was no formal system in place to monitor completion.

Maternity

We reviewed readmission rates and the reasons for readmission. There were 14 maternal readmissions from June to November 2022; the most common reason for readmission was hypertension which had been diagnosed in the ante/intrapartum period. There were 34 neonatal readmissions from June to November 2022 with the highest reason for readmission as jaundice. There was an infant feeding coordinator in place, and the service had made improvements to access to feeding support in response to patient feedback.

Midwifery Staffing

The service did not have enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service did not always make sure staff were competent for their roles. Appraisal rates in all staff groups were low.

The service did not have enough nursing and midwifery staff to keep women and babies safe. Staffing was the highest risk on the service's risk register. We found staff on labour ward were used to staff theatres and inductions of labour (IOL). During the inspection there were 3 midwives on labour ward, all of whom would be used to manage the elective caesarean section or IOL patients. We saw evidence which showed planned care was often moved due to the arrival of labouring women.

The number of midwives and healthcare assistants did not match the planned numbers. We reviewed the planned versus actual staffing for maternity services; no area in maternity services met their planned staffing requirements in any month from June to November 2022.

The service reported staffing red flag incidents (NICE) in line with national guidance. A red flag event is a warning sign that something may be wrong with midwifery staffing. There had been 85 red flag events reported in the 6 months prior to our inspection, figures reported for June 2022 peaked at 24, 12 in August, 10 in September and 9 in October 2022.

Despite the reduction in red flags reports the service continued to report incidents where there were not enough staff to meet the needs of women and birthing people, which impacted the delivery of care. In 6 months prior to our inspection, inductions of labour were delayed 42 times, there were 29 reported nurse staffing issues, 12 delays in treatment or clinical diagnosis and 2 occasions where staff failed to recognise deterioration. This impacted on timely clinical care and patient experience. Patients also told us about delays in in their care.

We reviewed incidents for the service for the previous 6 months and found 68 incidents reported where safe staffing levels were not met; 22 of these incidents resulted in delays to inductions of labour. Other impacts to patient care included delayed care provided, delayed planned caesarean section, and delayed discharges.

There were gaps in reporting fill rates to service leaders. In 3 of the previous 6 months staffing reports we reviewed, fill rates were not completed. Of the 3 completed months, neither the labour ward nor ward 21 had fully filled staffing levels. The most recent figures we reviewed showed that in September 2022, the labour ward had a 97% fill rate, and ward 21 had a 79% fill rate. The fill rate in May 2022 was 76% for labour ward and 88% for ward 21. Fill rates were not reported for June to August, so we were unable to determine if this was an improving picture.

We saw evidence that staffing was reported monthly to trust level committee meetings and bi-monthly to the trust board, which gave senior leaders oversight of staffing related metrics in maternity services.

Maternity

We reviewed monthly staffing reports between May to November 2022 (excluding August which was not provided) which showed how these events were managed which included redeploying staff, staff not taking breaks, staff working over their hours, senior and specialist midwifery staff working clinically and utilising the on-call hospital midwife.

We reviewed the maternity services staff survey results from 2021 and found some of the lowest scores relating to staffing; 5% of staff felt there was enough staff in the organisation to do their job properly, compared to 29% trust wide, 7% of staff had never or rarely find work emotionally exhausting or are worn out compared to 25% and 22% trust wide and 12% of staff felt they had realistic time pressures, compared to 27% trust wide. We also saw 74% of staff said worked any additional unpaid hours per week for this organisation, over and above contracted hours compared to 52% of staff trust wide. This reflected the shortfalls in staffing we saw during the inspection and what staff told us about staffing levels in the service.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. The service had last completed a nationally recognised acuity review in September 2021, which said the service had enough staff. This position had changed, and we saw the most recent staffing report sent to the trust's board in November 2022 showed there were 9 whole time equivalent (WTE) vacancies and stated there was a requirement for an additional 6 WTE midwives to the current funded establishment to meet safe staffing requirements. Vacancies had reduced to 3.31 in December 2022 but remained under the stated number to meet safe staffing requirements.

The service had conducted a skill mix review and recruited additional maternity support workers to support delivery of care in maternity services. The total absence rate across maternity services was 18%. In December 2022, average sickness absence was 9% across maternity services, with the highest percentage of sickness absence in the MAC and antenatal day unit at 16%.

The ward manager could adjust staffing levels daily according to the needs of women. Staffing numbers across maternity services fed into a daily staffing meeting and leaders dynamically assessed the numbers of staff available in each area; they moved staff across the footprint to provide a service as safe as possible.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used bank staff to supplement staffing; evidence provided showed on average, 11,414 hours of bank staff hours were used across acute and community services between June to November 2022.

There were 7.9 WTE specialist midwives which included the risk and governance lead midwife, risk management and clinical governance lead midwife, fetal monitoring, infant feeding coordinator, parent education, and bereavement midwives. The service also had an externally funded pastoral midwifery post. Specialist midwives worked clinically when needed to enhance the staffing in the service.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Overall, the maternity services achieved 61% of appraisals completed, which was below the trust target. Compliance for midwifery staff was below the trust target at 55%. Additional clinical services appraisal compliance was 50% and administrative and clerical staff compliance was 82%. We did not see any discussion regarding appraisal rates in governance meetings or in the minutes of leader's meetings. In addition, there was no evidence appraisal data reported to the trust board.

Maternity

In the maternity services staff survey results from 2021, 96% of staff who completed the survey said they had received an appraisal in the past 12 months, compared to 79% of staff trust wide, however only 4% of respondents felt the appraisal helped improve how they did their job, 9% were left feeling the organisation valued their work and 11% felt the appraisal helped agree clear objectives for their work. This indicated that performance in appraisals had declined since the previous year.

Managers made sure staff received any specialist training for their role. Most midwifery staff had received specific training and competencies around fetal monitoring and pool evacuation for midwives based on the labour ward.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number.There were no consultant vacancies, 0.20 WTE registrar vacancies and 1.2 WTE junior doctor vacancies.

Medical staff did not all have formalised job plans. Job plans were an annual agreement that set out duties, responsibilities, and objectives for the coming year for consultants. Job plans for medical staff were in the process of being defined at the time of the inspection. Some staff we spoke with had worked at the service for more than 3 years and had no job plan. The service was developing a system to ensure duties and responsibilities were covered by the clinical team.

There was enough medical staff to meet the needs of patients, however, staff told us the consultant on duty changed multiple times on some days which impacted on continuity of decision maker and patient experience. Service leaders acknowledged this was an issue and told us they were working to establish job plans and had worked collaboratively with medical staff to do so.

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

The service always had a consultant on call during evenings and weekends. There was enough consultant cover to meet national guidelines for consultant attendance.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Appraisal compliance for medical staffing was 100%.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely. However, they were not always easily available to all staff providing care and the records management policy was passed its review date and there was no routine quality audit of records in place.

Women's notes were comprehensive, and all staff could access them easily. We reviewed 12 sets of patient care records during the inspection. They were fully completed and included the expected assessments and level of detail in most areas.

Records were stored securely. Computers had password protection and swipe card access and paper records were stored in locked notes cabinets.

When women transferred to a new team, there were no delays in staff accessing their records. Most patient records were electronic, and staff could access relevant patient records across the pathway. Intrapartum care notes were completed on paper; we included a review of paper records in our observations and found they were completed accurately. However, staff did not always access electronic record systems to check safeguarding information and assessments that were in place and relied on verbal handover. Some staff told us patient records could be hard to follow due to the mix of paper and electronic records.

We did not see evidence of routine quality audits of records and the service did not provide evidence of auditing paper patient records, which were used in the service to document intrapartum care.

The service had a records management policy; it was version controlled, however was passed its review date, which was due initially in December 2020, and was extended to June and then December 2021. The policy had not been updated at the time of the inspection in December 2022.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up to date. We checked 4 medicines charts, which were recorded electronically, and all were completed appropriately.

Staff stored and managed all medicines and prescribing documents safely. We reviewed medicines stock checks, controlled drug checks and refrigerator checks during the inspection. All medicines were in date and stored appropriately and documentation was mostly up to date. Although, we saw a small number of gaps in daily checks in November 2022 on ward 21, managers told us this was due to staff absence.

The service had a medicines management policy; it was version controlled and due for review in June 2025.

Staff learned from safety alerts and incidents to improve practice. Staff articulated how learning from incidents was shared, including national updates. There was a bulletin shared regularly with staff which included highlights of incidents and learning for the service.

However, the service was unable to provide assurance there were systems in place to check staff competency when using medicines was in line with trust policy and national guidelines.

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 honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

Staff knew what incidents to report and how to report them. Staff told us there was a no blame culture and they felt comfortable reporting incidents. In the 2021 staff survey, we saw maternity staff scored higher than the rest of the trust in feeling secure to raise concerns about unsafe clinical practice and confident the trust would address those concerns.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The trust had a serious incident policy; it was version controlled and due for review in June 2024. The policy outlined clear roles and responsibilities in the management of serious incidents which included board reporting. We saw incidents were reviewed and discussed in line with the trust policy. Staff also reported serious incidents clearly and in line with trust policy. Staff told us the service completed case reviews which were MDT meetings to discuss incidents and take immediate actions; staff said they were proactive and no-blame.

The service had no never events on any wards in the reporting period.

Managers shared learning with their staff about incidents. Learning from incidents was shared through the service's risk bulletin which was sent to all staff; staff could articulate recent incidents and learning that had been implemented.

Staff received feedback from investigation of incidents. There were daily safety huddles which included feedback about incidents at every shift. Managers debriefed and supported staff after any serious incident. Staff gave examples of receiving good support following incidents and the staff could access trust psychological support services.

In the previous 6 months 2 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation; we reviewed 2 reports and actions plans and saw actions were in place to address recommendations and were monitored regularly. All actions were on track for delivery, and we saw they were linked training scenarios as well as sharing information through the service's risk bulletin. Each action included how compliance would be evidenced we found learning from incidents was shared in governance meeting minutes, as described in the action plan.

However, we found the action plans were not always updated, and although they reflected recommendations made, they did not reflect all findings identified in the report. For example, one action plan did not identify updates to a local policy were required as it did not follow national guidance. We reviewed the policy (vaginal birth after caesarean (VBAC)) and found it had not been updated and was past its review date.

Managers reviewed neonatal deaths as part of a multidisciplinary team, who used the Perinatal Mortality Review Tool (PMRT). The service had completed a review of those eligible cases using the Perinatal Mortality Review Tool (PMRT) in a timely manner and no deviation from guidance was found.

Evidence provided showed PMRTs were reported and discussed within the service and reported to board.

Leaders worked with other local NHS services to develop an external peer review process to review complex cases or cases of interest. We saw the service had completed a thematic review of PMRT of pregnancy losses and identified a theme around scans and estimated fetal weights; this was shared in the Local Maternity System (LMS) for wider discussion, who shared learning across organisations. The service had put an audit in place to review outcomes to monitor improvement.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff described actions they would take after an incident, including talking to women and families and providing written apologies in line with guidance.

Maternity

Staff met to discuss the feedback and look at improvements to the care of women. We reviewed meeting minutes where we saw learning from incidents was reviewed and staff told us learning was shared with them through regular bulletins.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Incidents were investigated and responded to in a timely way; there was 1 incident open over 60 days at the time of the inspection and it was under review.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders were on a journey of developing structures and processes to run the service. They understood and managed some of the priorities and issues the service faced but had not identified issues we found on inspection. However, they were visible and approachable in the service for women and staff.

The service was led by a director of midwifery, clinical director, and divisional director. There was also a deputy head of midwifery. The triumvirate were supported by a maternity matron. There were also board level executive and non-executive safety champions who supported the service.

The trust was in the process of updating the leadership and governance structure to improve lines of communication and define the structure of leadership meetings. It included some changes to leaders' portfolios which would allow them to maintain a primary focus on maternity services.

Leaders were clear on the new structures and lines of reporting.

The director of midwifery met weekly with other executive directors and could make urgent reports to the board so that changes could be approved. Leaders gave examples of quick decision turn around, including incentivised staffing to meet staffing demands. However, we found that not all concerns were reported appropriately, for example low appraisal rates.

The service had an integrated governance group, which had been the key meeting for all maternity related matters, risks, and issues to be presented and escalated.

Staff knew who the senior leaders in the service were and told us they were approachable and visible. Staff said they were supported by managers.

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 national drivers for improvement. However, the strategy was passed its review date.

Maternity

The service had a vision for what it wanted to achieve and had identified national priorities which drove the vision. The strategy had 6 aims:

- to ensure the delivery of high quality, safe services that are effective and efficient
- to create an effective workforce
- to work with service users
- to promote health & wellbeing
- to provide support for mothers with complexities including smoking, obesity, perinatal mental health, safeguarding
- to work collaboratively with partner organisations.

For each aim, the strategy identified pledges ("we will" statements) and actions (specific actions the service intends to take to achieve the aim). The strategy was version controlled; it was due for review in September 2022, and we did not see evidence this review had happened.

The maternity service strategy linked to the overarching trust strategy; we saw similar themes in the aims of the maternity and trust wide strategy, including delivering safe, high-quality care, working in partnership, and engaging with service users.

However, the strategy did not include any reference to continuous improvement, innovation and development which was a key priority in the overarching trust strategy.

We spoke to leaders about the vision and strategy for the service. They described the overarching vision and aims, and it was clear that progress had been made. Leaders also described additional areas of focus that were not reflected in the strategy and actions we saw, such as improvements to the induction of labour and VBAC pathways and the development of a dedicated caesarean section theatre list. These were newly developing priorities for service leaders to focus on.

Culture

Staff felt respected, supported, and valued most of the time. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women, their families and staff could raise concerns without fear. However, staffing shortages had impacted on staff morale.

Staff told us they felt respected, supported, and valued. We saw teams working well together to provide care for patients that met their needs, and there was an MDT approach. Staff in theatres appeared to work well together as a team and completed safety checks in line with guidelines. Staff told us they were supported to take on development opportunities and managers supported staff in new roles.

Women, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas. The service received no complaints in the 3 months before the inspection. One concern had been raised and the trust provided a response to the complainant with sign posting information.

Maternity

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw “you said we did” feedback posters on ward 21 which addressed breast feeding assessment and support concerns raised by patients.

Following our inspection, 22 women sent feedback about their maternity care at Airedale General Hospital. There were 11 responses containing positive feedback including caring, supportive staff and positive experiences, 6 responses containing mixed feedback and 5 containing negative feedback. We found 5 of the 11 poor experiences included care received on ward 21, with 3 negative experiences relating to breast feeding support and 3 negative responses around delays in induction of labour.

The CQC annual maternity survey results were published in January 2023; the service performed better than most trusts in 6 areas which highlighted positive experiences that women who used the service had, including being involved in decisions about antenatal care, being treated with dignity and respect, and being given enough support for their mental health. This showed positive elements in the culture of the service identified by patients.

The service completed an annual maternity services staff survey. The 2021 staff survey received 51 staff members in maternity services responded. . There were 7 overarching areas that the survey covered:

- Team,
- Managers,
- staff member's job
- Health safety
- Wellbeing at work,
- Personal development and
- The organisation and people in it.

Maternity services scored higher than the trust average in 15 out of 90 questions that had a response including: staff knowing their own and other people’s roles and responsibilities at work, enjoying working with colleagues, and feeling secure to raise concerns about unsafe clinical practice and confidence the trust would address those concerns. This suggested that there were elements of a positive culture in the service where staff worked together well and were able to raise safety concerns. The lowest scoring questions for maternity services related to staffing, overworking and staff feeling worn out.

The results of the survey were split into 9 themes:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

- Staff engagement
- Morale

Maternity services scored lower than the trust average in all 9 result themes; maternity services scored highest in the "we are compassionate and inclusive" and "we each have a voice that counts" questions, and lowest in "we are always learning" and "morale" questions.

After the inspection the trust provided the breakdown of results for the 2022 staff survey for maternity services, which covered the same themes and had 37 respondents. Maternity services scored lower than the trust average in all 9 result themes; the highest scoring areas stayed the same and the lowest scoring areas changed to "we are always learning" and "we work flexibly".

Maternity Safety Champions held regular meetings in line with national recommendations of meeting a minimum every 2 months. We saw minutes for meetings in September and November 2022, and found discussion was based on quality and safety metrics and indicators and there was an action log in place. However, in the 6 months prior to the inspection, the service had not always met this requirement; we saw minutes for January and May 2022 which meant there had been gaps between January and September 2022.

Governance

There was a lack of oversight on issues such as appraisals, training compliance, monitoring risk assessments and audits. Policies and documentation were not always kept up to date and action plans were not always completed or updated. However, leaders were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders were in the process of improving governance processes to ensure they were efficient and effective.

Managers reported monthly to the quality safety committee any concerns in relation to safety, quality, and performance metrics and evidence of actions to improve or understand the reported data. We reviewed the last 2 reports and found some risks and issues were escalated, and they were reflected in other reports we reviewed.

There were structures in place for relevant information to feed into the board and we saw this reflected in board reports we reviewed.

Senior leaders in maternity services met weekly. We looked at the action log from the November 2022 meetings, which showed items for discussion, actions, action lead, updates, and the status of each item.

The service had structures 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. All meetings fed into the Women's Integrated Governance Group (WIGG) which fed into the women's directorate integrated performance meeting (IPR). The IPR fed into a division wide IPR which fed into the Executive Directors Group and then to the board of directors. The director of midwifery reported to the board monthly.

WIGG meetings were held monthly. We looked at meeting minutes for the previous 3 months and found they covered key topics including incident and serious incident trackers and reports, risk and governance items, local and national updates, and monitoring performance in national schemes. The WIGG was chaired by the operational director and attended by leaders and managers in the service. Minutes from the meetings included actions and action owners and each item on the agenda had a responsible lead.

All reports, risks and issues went through the WIGG, which had developed into a catch all meeting. Leaders were confident in describing how the new structure would work and the trust had considered the timing of meetings to ensure staff required to attend had availability.

Service leaders worked to improve reporting and attendance of staff in forums to provide a broader representation. The medical staff roster system had been updated to provide regular opportunities for medical staff to attend governance meetings and there were ambitions for midwives to attend forum meetings. This work was in progress.

The trust had secured support from 2 patients to participate in various governance groups to represent the patient voice; this was reported to the trust board in November 2022 and had not yet been implemented in the service.

The board level maternity safety champions reported that engaging with people who used the service had been a challenge and work was ongoing to increase engagement. We did not see specific plans relating to this, as there had been no recent meetings, however, leaders described actions that were being taken in the service and at a local level, for example, the maternity voices partnership (MVP) had started to develop "maternity circles" which were local community-based drop in hubs that provide advice and support for women and babies; there were three planned for the Keighley area.

Leaders reported workforce pressure to the trust board and board papers reflected this. The service had reviewed staffing in September 2021 using a nationally recognised staffing acuity tool. The November 2022 board papers reflected the updated staffing position and reflected mitigations in place.

Staff did not always follow up-to-date policies and guidance to plan and deliver high quality care according to evidence-based practice and national guidance. There were 22 policies or clinical guidelines past their review date, including labour guidelines and slow progress in labour, record keeping, vaginal birth after caesarean (VBAC) and critically ill postnatally policies. We found some policies were unclear or confusing, for example the criteria for admission to the midwife led beds on labour ward.

We reviewed the maternal early obstetric warning signs (MEOWS) policy and found there were inconsistencies with the tools used on the wards. The MEOWS chart in the policy did not match the chart used in some areas of maternity services. We raised this with the trust during the inspection and they confirmed the paperwork in theatres was out of date; the trust told us this was removed from theatres to mitigate the risk of use.

We saw several documents across ward areas that were old and had not been reviewed in line with guidance. For example, on labour ward the documentation for bereavement in the staff guidance folders was issued between 2012 and 2013 had no review date. We saw a consent form with no review date from 2012 and we saw printed proformas for shoulder dystocia issued in August 2016, due for review in 2019.This meant in an emergent situation the service could not be assured staff were using documents which were up to date and followed current national or local guidance.

We reviewed consent forms used by clinicians in maternity services and found the consent forms did not always contain up to date information for all maternity procedures to meet national guidance. We also found consent forms that had been photocopied multiple times rendering some areas unreadable. For example, we reviewed the consent form for caesarean sections. It was version 4, last reviewed in 2012.; it did not meet current Royal College of Obstetrics and Gynaecology (RCOG) guidelines and had been photocopied numerous times with sections unreadable.

Staff did not follow a prioritisation process for calling medical staff when needed. Staff we spoke with were not aware of the trust's consultant attendance guideline which outlined when consultant presence was required to specific scenarios. We were not concerned that consultants did not attend when asked, however staff could not always articulate when consultants should be asked. The policy was introduced in August 2022 and although it followed national guidance, it had not fully embedded in the service.

Following the Ockenden Review, the service completed an assessment and assurance tool to assess their current position in relation to the 7 immediate and essential actions (IEAs) and the 10 Maternity incentive scheme safety actions. We reviewed the exercise and associated action plan the trust had produced in response. The action plan reflected the benchmarking exercise and actions that were needed to gain compliance with recommendations. We saw 50 of the actions were RAG rated as green (action complete), and 15 were RAG rated as amber (on track to complete) in November 2022. Target deadlines ranged from October 2021 (which pre-dated the action plan) to October 2022; the action plan was last reviewed, and RAG rated in November 2022. We saw 4 actions had no target completion date, so it was unclear how the service was monitoring the timeliness in completion of these actions.

In 1 action plan we reviewed relating to an HSIB report, an action was due for completion on 30 September 2022 and the status was "on track to deliver"; this had not been updated to reflect if it had been completed by the deadline and there was no commentary to describe any changes to the status. We did see action plans were reviewed in the service's governance meetings and were assured that actions were monitored, but the plans did not appear to be updated in a timely way.

There was an escalation policy in place to manage the department when it was experience increased activity; it was version controlled and due for review in March 2025. We saw actions were in place to mitigate risks and manage levels of staffing to the needs of patients. There were clear roles and responsibilities in the policy, and it was based on a national operational pressures escalation framework for maternity; it was adapted to reflect the specifics of the services provided at the hospital.

We reviewed the service's regional maternity quality dashboard. The dashboard benchmarked against the regional maternity performance. The dashboard reported on clinical outcomes such as level of activity, maternal clinical indicators including method of delivery and trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators and public health information. We did not see an internal quality dashboard that benchmarked against national or regional indicators or provide target figures to achieve. It was unclear whether indicators were showing improving or declining outcomes or performance against the indicators.

Management of risk, issues and performance

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

Outcomes for women were positive, consistent, and met expectations, such as national standards. The service complied with all 5 elements of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care. Out of 12 audits monitored through the maternity incentive scheme and required 80-94% compliance to meet the standard, and where compliance was less than 95% an action plan was required. The service had 1 audit below the threshold (73%) relating to providing reduced fetal movements leaflet and information by 28 weeks, and 2 requiring an action plan. All other audits were at 100%.

Maternity

The service participated in relevant national clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve women and baby's outcomes.

Managers established an audit programme to monitor improvements over time. There were 20 audits on the programme, 17 were live, 2 were planned audits and 1 was paused. No new audits had been registered in 2022. Of the 19 planned or live, 2 had been completed in line with the target date and four were ongoing and completed regularly. The remaining audits were passed the target dates and were aimed for completion between 28 February 2021 and 31 May 2022. There was no information on the audit plan to provide a narrative for the delays and no mitigating actions were evident on the document. There were gaps in the audit programme that had not been completed; 14 audits had no identified reporting group, 6 audits were outstanding or to be reassigned.

There was a monthly matrons audit, which included infection control, environment, cleanliness, medicines management and patient feedback. We reviewed the audit for ward 21 in November 2022 and saw there was a system to escalate concerns or non-compliance to the nurse in charge, however we did not see any related action plans or responses to evidence action had been taken.

The service did not provide evidence of a formal audit for the Newborn and Infant Physical Examination (NIPE) which screens babies for specific conditions within 72 hours of birth. The service told us that one person checked daily that all babies had their NIPE screen completed. We did not see evidence there was an effective system in place to check NIPE examinations in the case of absence. The impact of this is that new-born babies could miss vital screening opportunities.

There was a risk management policy which was version controlled and due for review in December 2022 (extended from March 2022). This was the overarching policy detailing risk identification, assessment and response criteria and clear reporting mechanisms for different risk scores, including the frequency of reporting and frequency of review. Risks that scored between 0 and 8 should be reviewed every 3 months and risks scoring 9 to 12 should be reviewed monthly. We looked at the overview data from the trust from December 2022 and found 17 risks on the register had review dates longer than 3 months, one was 12 months later in December 2023, and one was 9 months later in September 2023. Leaders reviewed the service risk register at the monthly WIGG meetings which was chaired by the divisional director, however we did not see risks were always reviewed in line with the trust policy.

Records showed that risk scores of 12 and above were reviewed and updated at each meeting. Risks with rising scores were escalated to the integrated performance review (IPR) meeting, and we saw in the last 3 months lower scoring risks were also discussed.

We reviewed a sample of risks and saw there were systems in place to record risks, mitigating actions, updates, and actions. However, we also found gaps in the documentation. For example, updates were not always added to the risk register to evidence when risks were reviewed at regular governance meetings. This meant it was unclear on the risk register when a risk was last reviewed, because updates were only added when there had been a material change. It was unclear from the risk register when the records had been reviewed with no changes. We reviewed a sample of 6 risks; 1 had no target risk score documented, 1 had a dating error which had not been identified despite the risk register being reviewed and 1 risk description was unclear.

The trust had an adverse event reporting procedure; it was version controlled, however was passed its review date of 31 January 2022. The policy described the different levels of incident investigation and which staff groups, or meeting structures were delegated to decide the level of investigation required. When we reviewed incidents and meeting minutes, we saw the service followed the trust wide policy.

Leaders reviewed serious incidents at the weekly at Quality Review Group (QRG) meetings. The purpose of this meeting was for the senior leadership team to gain oversight of incidents. We looked at the terms of reference and meeting minutes from the last 3 months. We found incidents were reviewed and actions were taken to further investigate or determine if more information was needed, in line with the terms of reference. Serious incidents and incident learning were discussed at the monthly WIGG, and we saw this evidenced in meeting minutes we reviewed.

The service fed into the LMNS (local maternity and neonatal system) monthly serious incident peer review panel, where they both presented incidents for peer review, and provided peer review for other services. We looked at the most recent minutes of this meeting and saw representation from the service attended and contributed to. There was opportunity for system wide learning and discussion about incidents, policies and procedures was included.

We reviewed the trust's perinatal clinical quality surveillance model and found there were systems to share perinatal clinical quality surveillance data. The trust had a communication and sharing guideline for the dashboard they produced which was in line with the minimum data sets set by NHS England. The guideline included a requirement to audit the dashboard quarterly and reporting structures were detailed, including local governance meetings, board reporting (alternate months at public board), reporting to the quality and safety committee (monthly) and sharing monthly with the LMNS and clinical commissioning group (CCG). We saw in public board papers the service had reported maternity quality, safety and performance and perinatal surveillance to public board which was held on alternate months, and local governance meetings, as detailed in the guideline.

The service used internal staff from different clinical areas to peer review working practices on ward 21 in February 2022 and labour ward in June 2022. Records showed that for ward 21, 22 actions were completed and 3 were on track for delivery, however the last review date on the 3 remaining actions was in August 2022 and they were passed their target completion date. We did not see evidence of more recent updates.

For labour ward, we saw there were 15 completed actions. The remaining 14 actions had not been completed by the target date or had no clear status. Ten of the ongoing actions had been identified as crucial changes. The pace of delivery was not timely, and we found similar issues during the inspection 5 months later.

The service had an Ockenden assurance visit in July 2022 to assess compliance with the 7 immediate and essential actions from the first Ockenden report published December 2020. The visit findings included 10 recommendations for the trust to consider making improvements, including developing the MVP and improving the guideline ratification process, and 12 noted areas of positive practice, including examples of positive culture and open, honest, and transparent staff. The 7 immediate and essential actions had criteria and the trust fully met 26 criteria and partially met 17 criteria. The trust board noted the receipt of the report at public board in September 2022 and was further reported in November 2022, included the trust's Ockenden action plan.

The service told us the report for the national MBRRACE survey had recently been published and a benchmarking exercise was being undertaken at the time of the inspection.

Information Management

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. However, staff told us multiple recording systems meant they struggled to access all information they needed.

The service had mostly electronic records and staff could access data, results, information and records they needed to.

Policies and procedures were held electronically, and staff could articulate where to find them.

Intrapartum patient records were completed on paper, and we identified concerns about staff routinely accessing and sharing safeguarding information that was held electronically when transferring the care of patients to other clinicians. Staff told us it could be difficult to find information they needed across systems.

The service had dashboards and submitted data to national databases as required. Dashboards, themes, and trends were reviewed in governance meetings and managers used data and insight reports to make decisions and improvements about care provision.

A weekly report was shared with the service to ensure correct data was recorded and could be extracted to inform external submissions. Data quality issues were fed back to teams, individuals and managers and training was provided where necessary.

Engagement

Leaders and staff engaged with women through local systems and were engaged in the development of these services. Listening events were used to engage with staff. The service collaborated with partner organisations to help improve services for women.

The service met with the commissioned local Maternity Voices Partnership Meeting (MVP) throughout the year. There had been changes to the MVP chair and the trust had engaged with interim chairs during this transition. Leaders were in the process of arranging meetings following changes to the MVP leaders and they planned to hold 4 meetings per year with additional service user meetings planned quarterly.

A local service user group was reinstated in January 2023, and they had met monthly since and this group had a dedicated representative at the MVP. The service continued to develop their workplan for 2023 with the MVP to continue to engage users and user voices.

The local MVP had an interim chair in place, and they had plans in early 2023 to agree a new chair and co-chair and define their roles and responsibilities. We saw the agenda for the meeting where this would take place. The service was committed to working with the MVP and board level maternity safety champions told us they, and senior leaders, were engaged in the process of welcoming new MVP leadership and working with them collaboratively.

There was no engagement plan for the MVP or strategy for engaging women who used the service to gain feedback and make improvements.

We looked at minutes from the most recent MVP meeting which was held in June 2022; we saw there was attendance from staff at the service who gave updates on maternity services at Airedale General Hospital. We did not receive an action plan to review because the MVP was in the process of being re-developed with new leadership, but we reviewed the work plan for 2023 which included a draft action plan.

The MVP had 5 goals which structured the draft action plan they planned to populate to achieve those goals: Development of MVP, Capturing, reporting, and acting on people's experiences of maternity care, developing an inclusive model for to ensure engagement across our whole BDC (Bradford District and Craven) footprint, influencing improvements in maternity care and outcomes and working collaboratively with key partners and programmes.

The service held a recent listening event with staff. The event had occurred in the week prior to the inspection and no feedback was provided. The service had planned regular listening events for labour ward and ward 21 based staff between January and April 2023.

Learning, continuous improvement and innovation

All staff were committed to learning and improving services. They implemented ideas to make improvements. Leaders encouraged improvements in the service.

Staff were committed to making changes, learning, and making improvements to the service.

The service had a quality improvement midwife; they signposted staff to nationally available quality improvement training and supported staff to develop. We asked about ongoing quality improvement projects and staff told us about initiatives to make improvements when they recognised themes; staff on ward 21 had introduced new feeding charts following an increase in readmissions of babies with weight loss. They had also implemented pressure area risk assessments.

Quality improvement was not always an item on meeting agendas, and we did not see evidence that staff were routinely engaged in conversation about their ideas and innovations.

The service had considered staffing and made changes to address gaps and skill mix. They had upskilled band 2 midwife support workers to become band 3 midwife support workers. This meant they had additional skills and competencies to support the service and address some of the staffing challenges as they were able to cover additional tasks. Leaders were reviewing how to further develop band 3 midwife support workers to invest in the future of this staffing model.

Referrals to stop smoking services had been a challenge for the service, and the trust had invested in nicotine replacement treatment and vouchers for patients; the service was in the early stages of training staff and developing the patient group direction (PGD). The service had improved stop smoking figures from 30% to 96% and staff were proud of this.

The bereavement care provided by the early pregnancy assessment unit was well thought through and organised; there were multiple resources available and the pathway in the service had been considered for patients with different outcomes.

The service's specialist bereavement midwife was named as a finalist for a national award for their work with a local support group offering support to bereaved families across Keighley and Craven, which was run by Airedale midwives. The support group was for anyone who has experienced the loss of a baby or young child.

Airedale General Hospital had a Sunbeam Garden with a tree of tranquillity in partnership, where parents could add leaves with children's name to honour them.

Maternity

Quality improvement work was reported to the trust wide quality and safety committee. In October and November 2022, the service reported that an audit was commissioned based on findings from perinatal mortality review tool (PMRT) reviews and other clinical indicators to review the outcomes of predicted ultrasound estimated fetal weights versus actual birthweight and whether this is in line with guidance. We saw this was linked to work being done in the LMNS to improve rates of stillborn babies.

Areas for improvement

Action the trust MUST take to improve:

Maternity

- The service must ensure care and treatment of service users is provided with the consent of the relevant person which is in line with national guidance. (Regulation 11 (1))
- The service must ensure clear systems are in place to prioritise and risk assess women, pregnant people and babies receiving care or treatment and do all that is reasonably practicable to mitigate any such risks. (Regulation 12 (2) (a) (b))
- The service must ensure Cardiotocography (CTG) fresh eyes are completed in line with guidance to assess the risks to women, pregnant people and babies receiving care or treatment and do all that is reasonably practicable to mitigate any such risks. (Regulation 12 (2) (a) (b))
- The service must ensure that safeguarding systems and processes are established and operated effectively to prevent abuse of service users. (Regulation 13 (2))
- The service must ensure systems embedded to assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity. (Regulation 17 (2) (a)).
- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of people who use the service. (Regulation 18 (1)).
- The service must ensure staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2) (a)).

Action the trust SHOULD take to improve:

Maternity:

- The service should enable timely access to evacuation nets for the birthing pools and this is monitored.
- The service should consider formalising systems to implement, monitor and embed quality improvements.
- The service should review the use of carpets in waiting areas and evidence they are cleaned in line with infection prevention and control guidance.
- The service should continue to engage in the development of the maternity voices partnership and develop systems to gain insight and feedback from people who use the maternity service.
- The service should continue to improve governance and meeting structures and facilitate wider staff group attendance.

Maternity

- The service should ensure cleaning checklists are in place for all areas of maternity services.
- The service should ensure there are systems in place to actively engage with women who use services.
- The service should work to enable maternity safety champion meetings to be held at a frequency in line with national guidelines.
- The service should ensure action plans evidence clear status and monitoring information to enable the service to monitor the timeliness and completion of actions.
- The service should ensure showering facilities available to patients are suitable to provide privacy and dignity.
- The service should embed systematic, structured handovers with clear roles and outcomes.
- The service should continue to develop systems and processes to ensure the risk register is up to date and accurately reflects the status of risks.

Our inspection team

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing