Bradford Teaching Hospitals NHS Foundation Trust

Bradford Royal Infirmary

Inspection report

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Ratings

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

Our findings

Overall summary of services at Bradford Royal Infirmary

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 Bradford Royal Infirmary.

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

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

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

We did review the rating of the location and our rating of this hospital improved.

We rated it as good because:

Our ratings of the Maternity service changed the ratings for the hospital overall. We rated safe as requires improvement and well-led as good and the hospital as 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

Requires Improvement ● →←

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

- Staff did not always manage risks to women, birthing people and babies well. There were not always enough staff to meet the needs of women, birthing people, and babies. They did not always manage medicines well.

However:

- The service provided training in key skill and supported staff to compete it. Staff worked well together for the benefit of women, there were effective processes in place to protect women and birthing people from abuse. The service controlled cleanliness and infection risk well. The service made sure staff were competent for their roles and provided supervision and appraisals. The service investigated incidents and shared learning with staff.
- 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 receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment, and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement ● →←

Our rating of safe stayed the same. 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.

We found inconsistency in staff's mandatory training compliance. The trust target for mandatory training was 85%. Support staff's training rates were between 84% and 86%; but nursing and midwifery staff compliance ranged from 80.8% to 86.1%. This did not always meet the trust 85 % target.

Most staff completed advanced life support and neonatal advanced life support training within the annual PROMPT session. Midwifery staff had compliance over 90%. Medical staff compliance with this training varied with Obstetricians' compliance ranging between 95% and 97% and Anaesthetists varying between 80% and 81%. The trust explained additional training was booked for anaesthetics staff in January 2023. This meant the target set by the trust of 85% was not always being met for anaesthetic staff due to the rotation of middle grade staff. Evidence provided during the factual accuracy process showed all anaesthetic trainees who worked within maternity services had current advanced life support certification. Staff completed regular skills and drills training. Staff completed yearly PRactical Obstetric Multi-Professional Training (PROMPT) sessions which included simulated obstetric emergencies including but not limited to: shoulder dystocia, post-partum haemorrhage and maternal collapse. Reflections and lessons learnt were discussed and documented after each scenario for the staff involved.

Maternity

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 95% and medical staff compliance was 89%. All staff groups met the trust target of 85%.

The mandatory training programme was comprehensive and met the needs of women and birthing people and staff. Staff told us training was delivered in a multidisciplinary (MDT) way and training was adapted to incorporate learning from incidents. There was a training needs analysis policy; it was version controlled and in date and reflected the training requirements for each role required.

The service had 1 full time band 7 practice development midwife and a consultant with 1 programmed activity in their job plan to support the delivery of training They were responsible for supporting the development of the training for midwives, ensuring that all training recommended as a minimum by local training needs analysis and national drivers over a 3-year period were covered. These included the Ockenden findings, Maternity Incentive Scheme and Maternity Transformation Core Competency Framework.

The service had increased the length of study days from 8.5 hours to 9.5 hours over 3 days to meet the required Ockenden, Maternity Incentive Scheme and Maternity Transformation Core Competency Framework standards. Live skills training sessions had been paused during COVID-19 but we saw that this had restarted in November 2022.

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked effectively with other agencies to protect them. Staff told us they asked women about domestic abuse and reviewed the risk of female genital mutilation (FGM) for all women. Audit data showed 99% of total deliveries in January 2023 had a routine enquiry completed at least once during the pregnancy."

Staff received training specific for their role on how to recognise and report abuse. Training records showed that all relevant staff had completed both level 3 safeguarding adults and level 3 safeguarding children training as set out in the trust's policy and the intercollegiate guidelines (2019).

The trust target for safeguarding training was 85%. Medical staff and midwifery staff overall compliance with safeguarding children training at level 3 was 89% and safeguarding adults' level 3 training was 100%.

Staff knew who the safeguarding specialist midwives were and spoke highly about the positive working relationship they had with the maternity safeguarding team.

Staff followed the baby abduction policy and we saw ward areas were secure, and doors were monitored. The service had reviewed the environment to improve the level of security and abduction drills were carried out to test the effectiveness of protocols. The service identified areas for improvement as part of these drills and improved the access control to the wards as a result.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Maternity

Women and birthing people could reach call bells and staff responded when called.

Some areas of the service did not have suitable facilities to meet the needs of women, birthing people and their families. We raised concerns in relation to how one of the waiting areas was managed because it did not facilitate the effective monitoring and oversight of patients or allow staff to easily identify if there was a deterioration in condition. This waiting area was shared by the maternity assessment centre, day assessment unit and antenatal clinic. After our inspection, leaders shared with us short term improvements made to the waiting area to allow identification of those attending the MAC. Further long-term improvements were planned to address the areas of concern which the trust had already identified a risk on the risk register since July 2021.

There was a bereavement suite away from the main labour ward area. It also did not meet the standards set out by the Department of Health's maternity care facilities document.

We saw broken equipment stored in corridors on the post-natal ward and labour ward. On the post-natal ward, a bed was blocking access to a patient toilet and a side room. We asked staff to review its placement and ensure facilities were accessible. When we returned to the area to check facilities were accessible on two occasions during the inspection, changes had not been made; we escalated this further, and the bed was moved. Following the inspection the trust told us the storage of beds in corridors had been risk assessed.

In other areas of the service, such as the birth centre and labour ward theatres, the environment was suitable, including appropriate lighting, birthing equipment, and appropriate décor.

The service had recently opened a brand-new maternity theatre suite in response to our previous inspection of maternity services 2020. This consisted of 2 spacious operating theatres and recovery area.

Staff carried out daily safety checks of emergency trolleys and resuscitaires across different areas of the service and most weekly failsafe checks were carried out. However, we saw examples of other specialist equipment being past their review date, such as a syringe driver, thermometers, and sonic aids. We discussed this with staff on the respective units for them to action.The backlog of equipment maintenance was a recorded risk on the trust risk register and staff had access to an inventory of all equipment.

Staff disposed of clinical waste safely. During the inspection, we found waste was appropriately disposed of and sharps boxes were completed in line with guidelines.

Staff on the birthing centre told us how they regularly flushed taps to manage the risk of legionnaires disease.

Cleanliness, infection control and hygiene

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

Maternity service areas were generally visibly clean and had suitable furnishings which were clean and well-maintained.

The trust system of labelling equipment after contact with women to show when it was last cleaned was not always consistently used.

Maternity

Audits of cleanliness we reviewed scored below the Trust's 90% target on initial audit but those that were re-audited improved to above the 90% target. One area which scored below 90% was still awaiting a second audit at the time of inspection. There were no themes identified across the across different areas of the service.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last 3 months compliance was consistently above 90%.

Assessing and responding to patient risk

Risks to care for women and birthing people were not always well managed.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately on the ward areas. The service tool called the Modified Early Obstetric Warning Score (MEOWS) to detect those seriously ill and/or deteriorating. This information was calculated in paper records because the new electronic system was not providing accurate calculations. Audits on the completion of MEOWS were completed in October 2020 which found that of the 50 patient records reviewed in some areas up to 50% of records reviewed were not completed as expected.

The service recognised that further guidance was needed for staff around when to complete a MEOWS. When electronic systems were introduced, a further audit was completed in December 2022 which reviewed 20 records which found that compliance had improved and 20% were not completed in line with guidance. The trust recognised further improvements were needed and had put an action plan in place to improve consistency. Updates to the electronic systems were awaited to calculate and document the MEOWS to reduce the administration burden and minimise room for human error by staff.

There was a maternity assessment centre (MAC) where women could telephone for over the phone advice from a midwife and if required, attend the department for clinical review. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The monitoring of maternity triage waiting times between May 2022 and November 2022 showed a high percentage of women (between 31% and 45%) were not seen within the trust target of 15 minutes. We talked to staff and leaders about their use of the triage tool, and they told us they had not achieved more than 70% compliance since implementing the tool. Improving the timeliness of initial triage within 15 minutes was part of an ongoing quality improvement project and had already been identified on the risk register. At the time of inspection, leaders told us they would expect women not seen within the expected timeframe to be re-triaged, however, staff told us, and we observed, this was not always possible due to capacity issues.

There were limited assurances about the safety, monitoring and oversight of women at risk who were attending the MAC service. This was a result of the physical layout of the environment and waiting times. Plans had been approved to improve this area of the service however these were longer term solutions. Following the feedback from inspection, short term measures were implemented to reduce the risk found on inspection. Further long-term improvements were also planned to address the areas of concern which the trust had previously identified as a risk on the risk register in July 2021. We saw Cardiotocography (CTG) documentation was not always documented in line with national guidance. CTG is used during pregnancy and labour to monitor fetal heart rate and uterine contractions. It is best practice to have "fresh eyes" or buddy approach for regular review of CTGs during labour. The trust had a centralised monitoring CTG and was auditing data for CTG and fresh eyes. The most recent CTG audit in December 2022 found fresh eyes reviews were not documented in 30% of records audited, initial risk assessments were completed for 90% of women but then hourly reassessment and escalation of risk was only documented in the correct place in 70% of cases. The service recognised that improvements were required to ensure consistent recording to evidence compliance and were working with system developers to embed better electronic systems.

Maternity

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. We observed use of the WHO checklist in theatres and saw all staff were fully engaged in the process. This was an improvement since the last inspection. We saw evidence confirming the trust was auditing WHO surgical safety checklist compliance, and actions were taken to make improvements when necessary.

We found SBAR (Situation, Background, Assessment, Recommendation) tools were used in patient records to handover key information and the same tool was used for shift handovers. The service had completed SBAR audits, and action plans put in place to address shortfalls in compliance.

Staff completed risk assessments for each woman on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 7 care records and saw risk assessments were completed at booking appointment and updated regularly. We saw risk assessments identified key factors such as age and health conditions.

We reviewed the service's maternity quality dashboard. The dashboard monitored themes and trends to inform decision making and improvements. Some areas of the dashboard were RAG (red, amber, green) rated in line with national and regional expectations. Although sepsis was not included in the dashboard this was monitored and reported separately. The trust provided us with information showing the ongoing work being developed to add additional indicators to the dashboard.

The dashboard reported on clinical outcomes such as mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (cot acuity, preterm delivery), induction of labour, public health information, workforce, and statistical analysis. Indicators relating to closures or regional data were not completed on the dashboard, however, were managed through board reporting.

- Between 01 April 2022 and 31 December 2022, 53 women were readmitted within 14 days of initial postnatal discharge. There was no information available for the number of babies aged 0 to 28 days were readmitted to hospital as a neonatal emergency readmission.
- Between 01 April and 31 December 2022, there were 25 still births and 21 neonatal deaths within 7 days of life. The service was a regional and national outlier for high number of stillbirths. This was recognised by leaders and the board were regularly updated. There were several initiatives in place to address this issue such as work with local food banks and providing transport to encourage attendance from women in financial hardship due to the service identifying deprivation as a potential risk factor. The trust had internal and external review of stillbirths when the number of stillbirths was above average for the month.

The service tried to ensure the provision of interpreting services for all women and birthing people that needed it. Evidence provided showed where there been a situation where staff hadn’t used interpreting services or felt it wasn’t needed was due to the acute scenario (29%) in line with trust policy, support of a bilingual colleague (26%), or an interpreter wasn’t available (29%) or being a native speaker of the language (4%). Following this survey the service had implemented the use of online, video interpreter services and were working towards making it clear which staff were bilingual, using badges to indicate this. The local policy correctly indicated that ‘family, friends, staff and carers should not be used to interpret unless there is an emergency situation and telephone interpreting is not available’ and evidence provided showed this was being adhered to.

Maternity

Midwifery Staffing

Staffing levels did not always match the planned numbers which exposed women, birthing people, and babies to risk, however leaders have effective escalation systems and processes in place to manage staffing levels. The service made sure staff were competent for their roles and provided supervision and appraisals which were slightly below the trust target.

Staffing levels did not always match the planned numbers. Information we reviewed about maternity fill rates between June 2022 and November 2022 showed a variation in actual staffing levels being available. Daily fill rates for labour ward, birth centre, antenatal and post-natal wards ranged from to 62% to 92% and night rates for the same wards varied from 53% to 100%. Staff told us they felt staffing levels were not always safe, however, the service was reviewing processes and models of care including maternity continuity of carer to release midwives to provide midwifery care to women and birthing people.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between March and September 2022 there were 49 red flag incidents relating to a shortfall in registered midwifery staffing.

The last full Birth Rate Plus acuity exercise took place in 2020/21 and papers were presented to the board in March and September 2022 which presented the data from the last 6 months around midwifery staffing. According to the Birth Rate Plus tool the current midwifery requirement for the service as funded was 279.77 whole time equivalent (WTE), in September 22 there was a variance of -18.1 WTE. The service was working towards safe staffing levels before gradually reintroducing continuity of carer.

Managers moved staff according to the number of women in clinical areas and the risk. Staff told us this was at short notice and had impacted on the number of times the midwife led unit had to be closed and impacted staff overall sense of well-being.

There was a policy in place for managing the department when it was in escalation. We looked at the policy and saw there were clear actions in place to mitigate risks and manage levels of staffing to the needs of women and birthing people. The service had adopted and implemented the use of OPEL (operational pressures escalation level) across the trust to ensure they were clearly communicating the risk within maternity services in a way that was widely recognised and understood across the Trust.

The service vacancy rates were monitored by leaders. There were ongoing recruitment plans in place, including international recruitment.

Staff could access support for women from a specialist perinatal mental health midwife and told us about good working relationships and access to out of hours mental health support.

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. The number of staff having completed an annual appraisal was 87% just below the trust target of 90%.

Maternity

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. Staff could access support from the professional development midwife and the addition of pastoral support midwife and 2 legacy midwives to support the workforce retention, recruitment, development.

Medical staffing

The service had enough medical staff to provide the right care and treatment to women, birthing people, and babies. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough staff to meet the needs of women, birthing people, and babies. We reviewed medical staffing numbers at the time of the inspection; 9 consultants had been appointed since November 2019, 5 of which were new posts. There was also 14 duel registered obstetrics and gynaecology consultants who support the on call rota which meant there were no gaps in the obstetric on call rota.

The trust recognised the strain on medical staff and the higher workload as a result of staffing shortages. Action was taken to try and reduce the risk of burnout. For example, rest days were scheduled after on-call duties.

The service always had a consultant on call during evenings and weekends. We saw red flag incidents were reported in relation to the availability of junior medical staffing which resulted in a delay in care being provided or reviewed. For example, from July 2022 – December 2022 there were 88 delays in medical reviews as a result of staffing and demands on doctors. There were also 5 incidents where epidurals were delayed due to a lack of available anaesthetic staff.

The service had low rates of bank and locum staff. Managers were in the process of recruiting a locum doctor and processes were in place to ensure locums had a full induction to the service before they started work.

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

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us that they felt supported to do their job by managers and they had good working relationships with management, other disciplines, and grades across the hospital. We found 64% of medical staff had received an appraisal which was appropriate for the beginning of quarter 4 as the appraisal year for medical staff runs from April to March, therefore none were yet overdue. There were 3 consultants new to the Trust who were not yet due to be appraised.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, up-to-date, or easily available to all staff providing care. Records were stored securely.

Care records were not always comprehensive, and staff told us they were not easily accessible. The service had introduced a full end to end maternity electronic record in the last 12 months.. We reviewed 7care records and found records were clear and complete, but information was not always documented on the electronic records as expected. For example, we were unable to find evidence of venous thromboembolism (VTE) risk assessment completed and notes for babies in the transitional care unit were not always comprehensive.

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

Records were stored securely. All computers were password protected and staff locked screens when computers were not in use.

Maternity

Medicines

The service did not always effectively use systems and processes to safely, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women mainly had electronic prescription charts for medicines that needed to be administered during their admission.

The service used an electronic prescribing system. Midwives used their midwives' exemptions to prescribe and administer medications within their remit. We reviewed 7 prescription charts and found staff had correctly completed them.

Staff did not always store and manage medicines securely. We found medicines were not always stored securely to ensure they could only be accessed by authorised staff. We found some medicines were out of date or had not been correctly labelled to identify the opened date and therefore the correct disposal date. These errors had not been identified on recent checks and audits carried out in the service.

Epidural medicines require 2 registered staff members to be witness their disposal; this was not always evidenced and so we could not be assured this was happening. The trust acted on feedback from the inspection to communicate this to staff and risk assess potential shortfalls. This was a continued breach from our previous inspection in April 2020.

Some medication rooms felt warm, and staff told us they often found them to be warm, however as the temperature was not monitored or recorded it was unclear if the temperature was above recommended limits which could potentially impact medicines were stored as directed. This could impact the effectiveness of some medicines. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff did not always check controlled drug stocks daily. The documentation of recorded checks was not always legible and did not always follow the trusts policy on how this should be documented. For example, 2 signatures were not always present, the time of the check was not always documented and there was no indication as to whether the stock check was correct. We escalated this following our onsite inspection and received assurance from the trust that actions have been taken to improve this.

Staff told us how they learned from safety alerts and incidents to improve practice.

Staff had completed medicines training; the number of midwives assessed as competent in the safe management of medicines was above the trusts 85% target.

The trust pharmacy team completed visits and staff told us they were advised on practice however this had not highlighted or addressed issues we found on inspection.

There was no dedicated pharmacy support for the maternity services and leaders told us this did impact on the level of assurance provided around medicines in comparison to systems in place in other areas of the hospital.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents however we were not always assured this was done in a timely manner. Lessons learned were shared with the whole team. When things went wrong, staff apologised and gave women honest information and suitable support.

Maternity

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system.

Incidents were not always investigated and responded to in a timely way; there were 54 incidents open over 60 days which were still under investigation and 11 were undergoing formal investigation. Nine incidents had been open for over 6 months.

We reviewed incidents reported by staff and saw these were not always appropriately graded. For example, incidents when women had sustained a 4th degree perineal trauma/tear, incidents when women had a severe haemorrhage or incidents when safeguarding concerns had not been well communicated to the relevant social workers had been classed as 'no harm'. *These incidents were investigated, and learning identified to prevent reoccurrence.*

There were incidents reported where the lack of interpreting services was linked to poor outcomes for women. The trust was taking action to make interpreting services more accessible and available. For example, technology was used to access remote interpreters, however the effectiveness and reliability of this equipment was inconsistent and there was no evidence to demonstrate the continued review of this issue. We saw the service followed the trust policy in terms of interpreting services.

The service had no 'never' events within the maternity service.

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

Staff received feedback from investigation of incidents, both internal and external to the service. For example, there were several forums where managers shared lessons learnt from incidents that had happened. Good practice identified from reviews of incidents was also shared. Staff told us about a closed social media group which they told us was effective in ensuring good accessible information and communication tool at a time that was convenient to them.

There were regular MDT meetings to discuss current risk across the service, feedback, and review improvements to the care of women.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. 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 staff. They supported staff to develop their skills and take on more senior roles.

Maternity

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. There were recent changes within the leadership structure and new roles within the midwifery service had been introduced. Staff told us this was still being embedded and they were not always clear of the senior management structure as a result but were confident that they could escalate any issues to their line managers which would be dealt with effectively. Staff told us they were well supported by their line managers, ward managers and matrons.

The service was led by a general manager, a midwifery director, and a clinical director. The triumvirate were supported through clear professional arrangements. The general manager and midwifery director were supported by a deputy operations manager and deputy associate director of midwifery. The clinical director was supported by the associate Clinical Director, Obstetric lead, and Gynaecology lead.

Leaders had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them were shared with staff; staff and leaders described how they were engaged, and their involvement encouraged. Staff told us how they had been supported in developing their career and training. Maternity support workers had been supported through clinical training and were now qualified midwives working at the service.

The service was supported by maternity safety champions and non-executive directors who attended multiple forums to listen to staff and birthing people on a regular basis.

Leaders told us they felt listened to and supported by the board and they were able to escalate safety concerns at the regular board safety meetings and sooner if needed.

We saw examples of staff escalating concerns to the safety champions in monthly meetings and action taken to address concerns.

The service had strong links to the Maternity Voice Partnership (MVP) to ensure the voice of people using the service were heard. The MVP were actively engaging with the local community and the service to drive improvements to birthing people's experience.

Vision and Strategy

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

The service's vision and strategy were outlined in their journey to outstanding maternity services (OMS). This was a program of work with 5 workstreams that all aimed towards creating an outstanding maternity service.

The vision had five priorities, each comprising specific actions with dedicated workstreams:

- Priority 1: Investing in our workforce
- Priority 2: A building fit for the future
- Priority 3: Moving to digital
- Priority 4: The women's journey and clinical excellence
- Priority 5: Linking learning through the quality of our information.

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The service had developed the vision and strategy in consultation with staff at all levels and staff spoke positively about the future of the service and could explain the vision and what it meant for women and babies. Staff were encouraged to put forward ideas at monthly meetings as part of the OMS project.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports and ensured the vision and strategy included these recommendations.

Progress was monitored and discussed in sub-group meetings and reported up to the board under the 5 priorities to ensure accountability.

Progress had already been made to varying degrees in each area. We saw the positive impact new surgical theatres had. The service was aware how the layout of waiting areas and assessment rooms were negatively impacting on effective triage, monitoring and oversight of women and birthing people. Plans had been approved but work was yet to commence in this area. Issues highlighted with oversight of woman attending the maternity assessment centre (MAC) led to some short-term changes to the environment made immediately following our inspection, to mitigate potential risk.

Changes had been introduced around the computer systems used within maternity and further work was taking place to embed and streamline these processes including further staff training.

Culture

Staff generally felt respected, supported, and valued. They were focused on the needs of women 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, their families and staff could raise concerns without fear.

Staff were mainly positive about the department they worked on and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. There were some areas of the service where staff morale was lower, due to staff being moved to support in other areas and the lack of dedicated staffing resources.

Annual staff surveys were carried out, with results reviewed and actions plans put in place and categorised under the 5 priorities of the OMS. Response rates to the survey had increased by 10% in the last year. Further engagement with staff to better understand the themes had taken place with action plans developed.

Staff felt there was an open culture and concerns could be raised without fear of blame. Staff told us they were comfortable contacting consultants and other medical professionals to escalate concerns when required. Staff spoke positively about support they received from specialist midwives such as the safeguarding midwives and the perinatal midwife. They gave examples of how they had worked together to ensure positive and safe care was provided to women.

Leaders understood how health inequalities affected treatment and outcomes for women and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and interrogated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. Initiatives had been introduced within the service to address issues around deprivation and poor outcomes. For example, the service had made links with local food banks and made sure food was available to support those attending long appointments. The service had also provided transport for women to ensure they did not miss essential appointments.

Maternity

An independent thematic review had been commissioned to look for trends due to higher-than-expected numbers of stillbirths over a number of months. Recommendations were made for increased scanning of women of a Pakistani origin due to upward trends and risks associated with babies small-for- gestational age (SGA). At the time of our inspection the service had implemented all of the required urgent actions which came out of the review and were in the process of sharing the recommendations with the trust board.

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

The service had an open culture where women, their families and staff could raise concerns without fear. The service clearly displayed information about how to raise a concern in women 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.

We reviewed all complaints and found that themes included women and birthing people feeling complications had not been identified or their concerns not been listened to which led to more difficult experiences of birth and their treatment. We found complaints had been responded to in a timely manner and in line with the trust policy. Outcomes from investigations and complaints were shared at the monthly governance meetings and feedback and learning disseminated to staff.

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 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.

There was a governance group in place which was well attended by the multidisciplinary team. Monthly directorate governance meetings were held and chaired by the Consultant Obstetrician & Gynaecologist. Relevant information was escalated to the Trust quality subcommittee, which feeds into the trust board.

There were opportunities for managers to meet with the senior management team monthly. We looked at meeting minutes for the last 3 months and discussions were held around stillbirth rates, staffing, investigations and updates on actions, recommendations, and risk.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board. Staff knew how to escalate issues to the clinical governance meetings and divisional management team. Staff and leaders were also able to explain how issues had been raised between meetings more informally.

There was a process in place to track and monitor, guidelines, policies, and standard operating procedures. Where guidelines had exceeded their review date they were reviewed by the consultant lead and risk assessed if there still met national guidance. Where there was extensions in review dates this was discussed within local committee and agreed.

Maternity

Following the Ockenden Review, the service completed a benchmarking exercise. We looked at the outcomes of the exercise and associated action plan and saw that positive feedback was given around areas including ward to board communication and the ongoing outstanding maternity services project. Recommendations were made which generated an action plan being implemented with appropriate timescales. There were 7 actions on-going and two had been closed at the time of the inspection.

There was a policy in place for managing the department when it was in escalation. We looked at the policy and saw there were clear actions in place to mitigate risks and manage levels of staffing to the needs of women and birthing people. The service had adopted and implemented the use of OPEL (operational pressures escalation level) across the trust to ensure they were clearly communicating the risk within maternity services in a way that was widely recognised and understood across the Trust.

Management of risk, issues and performance

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

The service had a risk register in place. We reviewed the risk register and saw that out of 20 identified risks there were 3 with a high residual risk. The majority were categorised as low (13) due to effective mitigation.

Target dates set were realistic based on the resources required. Each risk had an assigned person to manage the risk and there was a process to escalate risks as required. The trust had an incident investigation policy which showed how to report, manage, escalate, and communicate concerns appropriately. When we reviewed incidents and meeting minutes, we saw the service did follow the trust wide policy.

Incidents were reviewed at the quality and safety meetings which were held monthly. We looked at the most recent minutes and found good attendance from the MDT, appropriate sharing and updates around investigations and monitoring of actions. Datix incidents were reviewed Monday- Friday by the quality and safety team and allocated to an appropriate investigator. However, we found that incidents were not always consistently or correctly categorised to the appropriate level of harm which could impact the level of scrutiny and investigation.

There was an effective system in place to review and monitor actions from HSIB investigations. We looked at minutes from board meetings for the last 6 months and saw that updates, actions, and recommendations from HSIB reports were discussed at board level. Outcome reports from the HSIB investigations were included as part of the board report papers.

The service participated in relevant national clinical audits. Where outcomes for women were poor or worse than expected the service looked to investigate these further. The trust recognised they had a higher-than-expected number of still births in some months. The service had an independent review in November 2022 which looked at the stillbirths in 2022, this was a fresh eyes approach following individual clinical 72-hour reviews. Findings from this review were shared at board level.

The Maternity Incentive Scheme is a national programme that rewards trust's that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with all 10 out of 10 safety initiatives. We saw they had provided sufficient evidence of their compliance to the board over the last 6 months.

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The service complied with all 5 out of 5 saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

The service provided up to date data to the national MBRRACE survey. We looked at actions from the survey and saw they reflected issues identified around number of stillbirths and potential contributing factors such as high levels of deprivation. Action was taken to try and reduce the impact of this by way of initiatives involving food banks and support with transport to avoid missed appointments.

Since May 2022 the trust had an agreement with another local NHS trust to undertake external peer review at perinatal mortality meetings. We looked at the outcomes of the exercise and associated action plans and saw that care was reviewed, learning and improvements identified, and action plans generated.

We reviewed the trust's compliance with the perinatal clinical quality surveillance model and found that they were regularly reporting to the board as required.

Oversight of safety in maternity services was reported to the board monthly. We reviewed the last 6 reports and found the board were appropriately sited on the current and on-going risk, progress made and potential barriers to progress. The board were made aware of all ongoing investigations around perinatal and maternal deaths as well as compliance with all maternal safety initiatives and schemes. However, information around the impact of communication/language barriers and the limitations to technology currently used was not always made clear to the board.

Information Management

The service collected reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

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

Staff told us that they could not always find the data they needed since the new computer system had been introduced. This could lead to information being categorised incorrectly and information not being readily accessible when needed. The service and staff were aware of the shortcomings of recently introduced systems and processes to make improvements. Whilst these improvements were being made, staff were provided with on-going support and training as part of the digital teams workplan.

The information systems were integrated and secure.

Data and notifications were consistently submitted to external organisations as required. Where there were gaps in reporting there were contingencies in place to develop systems as required.

Engagement

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

The service held monthly engagement sessions with staff. They collated the feedback given in these sessions and a "you said, we did" newsletter was then produced and circulated. We saw how that feedback was used to make improvements or changes to the service. For example, concerns were raised about community midwives lone working and the devices used not being effective; all community midwives were then issued with a mobile phone to enable safe lone working in the community.

Maternity voices partnership engagement meetings were scheduled every 8-12 weeks and they held regular informal sessions and attended events to hear from individual parents and voluntary community sector partners. Their role was to work on collaborative projects with both maternity teams and other partners, to improve people's experiences of care. We looked at minutes from the last 3 meetings and saw that the MVP were provided with regular updates from the Trust on on-going actions to improve services from women and birthing people. Work was taking place to involve those from ethnic minorities.

There had been a successful event called 'All Things Maternity' which was an involvement event held in Keighley and Bradford; this reached 86 parents including many from Pakistani, Bangladeshi, and Eastern European communities. We saw shared learning from wider research projects and national guidance was discussed.

In October 2022 the chair of the MVP had stepped down and an interim chair was in place whilst recruitment was on-going. This MVP and service recognised that this had impacted on the quality and involvement of the MVP whilst there was no permanent chair appointed.

The service collected data on the ethnicity of people using the service and leaders understood the demographics and the needs of the local population. The service safety champions, and other leaders worked closely with the MVP to understand the issues faced by women and birthing people and had introduced initiatives to reduce barriers and inequalities.

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.

The Trusts outstanding maternity services (OMS) transformation project launched in November 2020 and was the workstream driving quality improvement. There were 5 smaller project work streams as part of the wider OMS project, that all had regular monthly meetings which then fed into an overarching monthly OMS meeting. We saw that quality improvement was broken down under the 5 workstreams and was always an item on the agenda. Staff were actively involved and engaged in both the development of the project and conversations about their ideas and innovations.

Learning from incidents, audits and feedback fed into this project and directed learning and change which was communicated well with staff. Specialist midwives and champion roles co-ordinated development of quality improvement initiatives under the 5 sub-groups.

The service had appointed a professional development midwife, a pastoral support midwife and 2 legacy midwives to support the workforce retention, recruitment, development, and well-being which we recognise as good practice.

Outstanding practice

We found the following outstanding practice:

Maternity

- New surgical theatres had been purpose built for the maternity services and had been designed to ensure the best possible environment for staff and birthing people.
- The outstanding maternity services project provided a sense of direction, vision and engagement with staff at all levels. This created a sense of ownership over the improvements required and encompasses both local level and national initiatives.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The service must ensure the safe and proper use, administration, recording and storage of medicines. (Regulation 12 (2) (g)).
- The service must ensure medical staffing for maternity triage is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1))

Action the trust SHOULD take to improve:

Maternity

- The service continue to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed to meet the needs of people who use the service.
- The service should continue to make improvements to the maternity services waiting areas to ensure effective oversight of patients waiting to be seen can be maintained.
- The service should improve completion of equipment checks in line with trust policies and appropriate maintenance schedules.
- The service should continue improve access to interpretation services for women and pregnant people.
- The service should ensure staff always complete and update risk assessments and applicable key documentation (including modified early obstetric warning scores, and intrapartum ‘fresh eyes’) for each woman.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 4 other CQC inspectors and 3 specialist professional advisors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.