

Maternity Improvement Advisor Diagnostic Report

Trust: The Leeds Teaching Hospitals NHS Trust

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1. Background

The Maternity Safety Support Programme (MSSP) team undertook the diagnostic visit at Leeds Teaching Hospitals NHS Trust between the 17th and 20th March 2025 following multi stakeholder intelligence gained from a rapid quality review meeting held on the 31st January 2025. The methodology included the review of Trust documents, meetings with executive team, opportunities were taken to attend key service meetings both during and following the visit, host both individual and group focus, sessions walk abouts around the clinical areas and service user engagement.

The NHSE team were also joined by regional colleagues, service use representatives and NHSE neonatal colleagues. Neonatal colleagues were not undertaking an independent review of the neonatal services.

NHSE / Regional Team members

Amanda Pearson	National Maternity Improvement Advisor
Scott Johnston	National Maternity Improvement Advisor
Suzanne Cunningham	National Maternity Improvement Advisor
Simon Meighan	National Maternity Improvement Advisor
Sandra Smith	National Maternity Improvement Advisor
Lesley Heelbeck	National Maternity Improvement Advisor
Susie Al –Samarrai	National Obstetric Maternity Improvement Advisor
Nikki Burnett	National Service User Voice (SUV)
Emma Crookes	National SUV
Sarah Wall	National SUV
Chris Binnie	National SUV
Debi Gibson	National Maternity Improvement Advisor
Tracey Cooper	Regional CMIDO

Claire Keegan	Regional Deputy CMIDO
Ngozi Edi-Osagie	National Neonatal Lead
Louise Weaver Lowe	National Neonatal Nurse Lead
Kelly Phizacklea	Neonatal SUV
Caterina Raniolo	National Maternity Quality Improvement Lead

2. Executive summary

Whilst Leeds Teaching Hospitals Trust maternity services have received positive feedback and are implementing innovative practices, significant concerns regarding safety and quality of care persist. Addressing these issues through systemic reforms, enhanced staffing and a culture shift towards patient centred care is imperative. To ensure the well-being of the mothers and babies in Leeds.

The service has had a challenge in responding to families who have experienced harm and poor outcomes. This has led to several parents requesting an independent inquiry. The Trust executive team were aware of the need to adopt a more trauma informed approach and were committed to improving and learning from service user experiences.

The systems and processes in relation to governance framework in maternity and the wider organisation could be strengthened. Learning from incidents, was not robust and therefore there was a continuation on previous identified themes.

The culture of the organisation was challenging and came across as a degree of negativity rather than supportive with lack of communication being a theme through all the staff meetings and a feeling of 'being done to'. This had led to escalation fatigue from the staff as they did not feel that their safety concerns were listened or responded too in a productive and supportive way.

The visiting team would like to take this opportunity to thank the teams at The Leeds Teaching Hospitals NHS Trust for welcoming us to their unit and to the staff for their open and honest reflections of the successes and challenges within the service.

At the end of the visit high level feedback was provided to the executive and senior midwifery teams.

3. Areas of good practice

- Excellent cross site working for both obstetrics and midwifery
- Transitional care at St James is staffed appropriately by midwifery and neonatal staff
- Guidelines and pathways are harmonised across the two sites
- Clinical Specialist Midwives, support staff to use pathways to support women
- Hot debrief used in Neonatal Unit (NNU) but not maternity
- Solution focused staff with a willingness to improve services
- Consultant midwifery has positive relationships with wider system / public health innovations
- Cohesive obstetric team, good Multi-Disciplinary Team (MDT) working, embedded handovers
- Engagement in PMRT process from a neonatal perspective good
- Units were clean and staff welcoming
- Neonatal Life Support (NLS) undertaken out of hospital with paramedics and community midwives

4. Areas of concern

Areas of concern highlighted in high level feedback

- Lack of CTG machines (highlighted by the CQC in January) to enable women to be effectively and safely monitored
- Lack of Cell salvage at Leeds General Infirmary (LGI) site
- Intercom and CCTV in Maternity Assessment Centre (MAC) at LGI is broken and has been intermittent for several months and there is a risk to women accessing the unit and to staff safety. Staff describe being frustrated by complicated escalation process and lack of feedback to progress currently on the risk register
- Lack of systematic maternity triaging process, plan to introduce in April 2025 this should be a priority
- Compassionate communication to service users through incidents and complaints
- Staff describe safety concerns being de-escalated without resolution of concerns
- Leadership roles in obstetrics not embedded and are not clearly visible to staff
- Obstetric / midwifery skill mix
- Triage/BSOTS best practice RCOG guidance not being followed

Identified areas of concern

- Maternity leadership on the LGI site should be rapidly improved
- Review specialist and senior midwifery posts required to support a safe and effective service
- Medical staff presence in MAC and DAU
- Reluctance to escalate escalation fatigue
- Incivility and poor communication, recent example regarding 50% clinical working for team leader, undertaken by e mail with no discussion then retracted
- Introduction of agency midwives with no discussion to team leaders changes to EKCS pathway
- Escalation process especially out of hours – no clinical or midwifery management on call
- No rapid staff debrief process in place following incidents
- PMRT process / complaints
- Obstetric PA allocation for fetal monitoring
- Signage / Perspex barriers / lack of visible service user information / language availability

5. Overview of the service

Leeds Teaching Hospitals NHS Trust (LTHT) provides comprehensive maternity services across two main sites St James University Hospital (SJH) and Leeds General Infirmary (LGI) with a 2-mile distance between them; a shuttle provides transport for staff who work cross site. The Trust covers a diverse population with over 75 ethnic groups and delivers approximately 8500-9000 births each year split equally across both sites.

LTHT hosts one of the largest fetal medicine units in the north and is a Placenta Accrete Spectrum Centre.

The maternity services sit within the Women's Clinical Service Unit (CSU) inclusive of maternity and gynaecology. Neonates sits within a separate CSU, the Children's Hospital CSU.

The service should be commended for the outstanding cross site working and clinical pathways that are in place and could be an exemplar to other units forming group models.

SJUH Maternity unit comprises of

- Antenatal clinic (including obstetric haematology/cardiac)
- Antenatal day unit
- Maternity Assessment Centre / Fetal Assessment Unit

- Screening team
- Antenatal ward 12 beds
- Postnatal ward. 29 beds
- Labour ward 10 beds including 1 EMC, 1 bereavement room, 3 side rooms and 4 recovery beds

Neonatal services

- 16 cots
- 13 Transitional care

LGI maternity services comprises of

- Antenatal clinics (including diabetes and maternal medicine)
- Antenatal Day Unit
- Maternity Assessment Centre
- Fetal Assessment Centre
- Fetal Medicine Unit
- Antenatal ward 22 beds
- Postnatal ward 22 beds
- Labour ward 9 bed, 2 bereavement rooms, 5 EMC/recovery and 2 antenatal beds
- 3 midwifery led care rooms

Neonatal services

- 14 intensive care cots,
- 10 high dependency cots
- 6 transitional care
- Tertiary centre for Neonatal Congenital Cardiac Care. Average of 1500 admissions per year

Community Midwifery

- 24 teams (16 standard, 8 specialist)

6. Workforce

There is no documented perinatal workforce strategy for the CSU which would help planning with escalation recruitment and retention, a cohesive workforce plan and strategy will enable the service to benchmark quality and safety aligned to national safe staffing requirements and standards this should be inclusive of pastoral support and succession planning for both midwifery and obstetric staffing.

The Birthrate plus 2024 report highlighted the need for 12.6 WTE clinical midwives and 14.5 WTE nonclinical specialist midwives. The service has been supported to recruit to the clinical midwives, but not to the non-clinical midwifery posts. The Head of Midwifery has submitted a workforce paper; however, this is yet to be approved this will be reviewed by the newly appointed Interim Director of Midwifery for submission and approval.

The CQC raised concern around the clinical midwifery staffing numbers and fill rates and monthly submissions have been submitted. Maternity leave is currently not backfilled appropriately therefore the staff are still feeling the reduction in numbers on clinical shifts.

Recommendations

1. The Trust would benefit from the development and implementation Perinatal workforce strategy to be developed inclusive of the review of current uplift and backfill for maternity leave
2. The Trust should consider reviewing the senior midwifery structure in line with Birthrate plus to provide assurance of strong leadership and visibility on both sites

6.1 Senior executive leadership

There is one overarching executive team over both sites with CSUs, with maternity sitting within the women's CSU alongside gynae. Neonatal services sit within a separate CSU and therefore this creates a disconnect between the two services. Combining maternity and neonatal services allows for a seamless coordination between obstetrics and neonatal team. This model improves the management of high-risk pregnancies and ensures that babies requiring neonatal support receive immediate specialised care without delays or handovers between departments, therefore supporting and facilitating clearer communication and more cohesive decision making.

Recommendations

3. The Trust could consider the benefits of having maternity and neonatal services within the same CSU. Having maternity and neonatal services within the same CSU offers several strategic and clinical advantages that directly benefit patient outcome, care, continuity and operational efficiency.

6.2 Midwifery leadership

The midwifery leadership team have been part of significant changes within the organisation over the last year. The leadership is challenged by the instability in the Director of Midwifery

role and several senior midwifery leadership specialist posts being interim appointments. There is a need for leadership support and development within in these roles to clearly define roles and responsibilities.

The visiting team reviewed the leadership structures provide by the Trust prior to the visit, the Birthrate Plus (BR+) report (March 2024), board papers and discussed the leadership structure with the leadership teams and staff when on site. A follow up visit also took place post visit to meet with the head of midwifery (HoM) who had been on planned leave during the visit.

The substantive DoM resigned in early 2024, the previous interim arrangements in place were for the role to be undertaken by Deputy Chief Nurses which was a decision made by the executive teams. Whilst the deputies who undertook this role were experienced nurse leaders, they were not registered midwives and did not have the necessary midwifery leadership experience and understanding to lead a complex dual site maternity service.

An interim Director of Midwifery / deputy Chief Nurse (DoM) has recently joined the service and had been in post for two weeks prior to the visit. The DoM portfolio has leadership responsibilities beyond maternity and includes women's services, neonates and a plan to incorporate safeguarding. There is however a current ask to focus on maternity, but the job description remains with the wider portfolio. Given the leanness of the current maternity leadership structure and the leadership ask that will be required to drive forward ongoing improvements in maternity, the wider remit of the DoM role should be considered when reviewing the overall midwifery leadership structure.

On the LGI site multiple members of staff highlighted a lack of visibility of midwifery leaders on that site. Given the significantly low numbers of midwifery leaders (as noted by the visiting team and identified by BR+) this is understandable. The midwifery leaders explained that they do visit the clinical areas when on that site however due to their large numbers of areas to manage, their dual site roles and the location/availability of office space on that site, this is challenging.

Recommendations

4. The Trust to consider the DoM portfolio to be just maternity and neonates with the focus on the Director of Midwifery and not Deputy Chief nurse.
5. A review of the senior midwifery roles required to lead the service alongside a review of all interim roles would be beneficial to provide a higher level of assurance and removing the uncertainty for staff around interim roles.

6. The Trust could benefit from reviewing and outlining key roles and responsibilities for the senior midwifery team to provide a higher level of assurance.
7. The Trust to consider further investment in leadership programmes for the senior perinatal team to support ongoing development and succession planning.

6.3 Head of Midwifery (HoM) / Deputy HoM

There is a substantive HoM and deputy HoM in post who provide cross site cover although presence is very much on the SJH site. They have a good understanding of the service requirements and are sighted on the challenges and successes. The visiting team noted the leanness of the senior midwifery leadership structure and the wide remits that the HoM and deputy HoM were currently undertaking, particularly in the recent absence of a DoM. The HoM and DHoM were in the process of undertaking the Aspiring Leaders Course.

Recommendations

8. In response to the Birthrate plus report, the Trust should consider increasing the midwifery leadership structure to support clear cross site and site-specific cover to ensure assurance is provided around the quality and safety of the service and positive experiences for women and their families. Site specific matrons and flow midwives would further enhance the quality and safety of the services whilst also increasing the senior midwifery leadership team and improve the visibility and availability for immediate senior support in the clinical areas.

6.4 Perinatal Leadership Team working

There is limited recognition of the perinatal leadership team and how this can be effective in providing a consistent and multi-disciplinary (MDT) approach to quality, safety and appropriate escalation of risks. Neonates are not currently included, and all senior leadership refers to the triumvirate (Obstetrics, Midwifery and Operations). The staff refer to the triumvirate and it is unclear how the triumvirate escalate concerns, in line with Maternity Incentive scheme year 6 the safety champions do not attend the Triumvirate meetings and no evidence was presented to be reviewed of separate safety champions meeting during the visit

Recommendations

9. The Trust should consider having a fully established Perinatal Leadership team with clear, terms of reference, lines of reporting and escalation, this will provide a higher level of oversight and assurance for the Trust board. The Perinatal

Leadership Team should be inclusive of neonates and consideration for including anaesthetics and service user representation would ensure complete oversight of clinical services, risks and experience.

6.5 Obstetric leadership

The CSU Clinical Director (CD) has been in post for two and a half years (3-year tenure with option to extend) and provides cross site leadership. The CD is a named safety champion

Lead roles	Allocated Pas
Clinical lead for obstetric	2 PAs recent increase from 1
Labour ward lead	0.5 PA
Fetal Monitoring Leads	0.5 PA per site
MAC / ANDU lead	0.5 PA
Wards	0.5 PA
Outpatient / Community	0.5 PA
Risk	1 PA
Governance	1 PA
Guidelines /Audit	1 PA
PMRT Lead	1PA
MNSI lead	0.25 PA

The PA allocation for these roles was variable and not necessarily reflective of the requirements of the role. There were also concerns that the fetal monitoring lead PAs were not in line with the requirements set out in SBLCBv3 (1PA per site)

6.6 Obstetric workforce

There are 24 consultants working across the two sites with an overall on-call frequency of 1 in 10. The consultant is job planned to be resident on site until 2200 following the ward round with the night team. They describe using the entrust ability framework and the role of the consultant documents from the Royal College Obstetrics Gynaecology (RCOG) to support

on site presence for high-risk situations or where there are situations of high activity. Feedback from the wider MDT suggested there would be more usually in attendance in those situations but that there were occasions where escalation for support was responded to in a sometimes-surly manner which in turn there could be a reluctance to call for support. There are no obstetric job plans that have DCC activity on the day following a night on call.

There is work ongoing to undertake a workforce review of the consultant team, to reflect the age profile and potential risks and opportunities to expand and develop the team. There is also an awareness across the department as well as in the executive team that the number of consultants in the team needs to be increased.

6.7 Resident doctor workforce

There are approximately 35 resident doctors on the rota, but a significant gap is being anticipated with many doctors due to go on maternity leave in the coming months. This has resulted in a planned change to the on-call rota to increase the frequency of on call shifts. There does not appear to have been any significant consultation with the resident doctors regarding this proposed change which was fed back to the visiting team during the MSSP visit.

Existing gaps in the rota are causing concerns to both resident doctors as well as consultants as there are frequently episodes of consultants 'acting down' to cover, especially between 5 and 9pm. Resident doctors reported a reluctance to fill gaps due to a perception that locum rates were significantly lower than for neighbouring Trusts and that escalated rates would only be approved at very late notice. This was also reflected by consultants describing having to provide cover for the gaps, also creating concerns about limited cover for escalation on the LGI site if the consultant is acting down.

At LGI, there is a single tier of 'registrars' on call overnight supported by a junior tier of resident doctors providing cover

At SJH there is one registrar covering obstetrics and one covering gynaecology who may be available to support obstetrics if required due to activity/acuity. They are supported by a single doctor on the junior tier who is covering obstetrics and gynaecology overnight.

There is a Resident Doctors forum where issues are discussed between the resident doctors, but it was not clear whether there were any representatives from Human Resources (HR) or from the leadership team as issues being raised were often not resolved.

6.8 Anaesthetic workforce

Anaesthetists do not currently rotate between sites they report positive working relationships with all members of the wider obstetric and midwifery teams. There wasn't the opportunity during the visit to meet with many of the anaesthetic team and this can be followed up at any further visit.

6.9 Neonatal workforce

Neonatal services are provided across both sites, with staff rotating on six-month placements. Recruited 16/21 vacancies with a predicted 0 WTE gap from September 2025.

SJUH Neonatal

There has been a Change to the pathway from SCU+ to SCU which had received previous Operational Delivery Network (ODN) approval for SCU+ from 2020. The number of cots has formed part of this change from 21 to 16 cots. Staff reported the redesignation has had a significant impact on staff morale as staff reported that that this has removed their autonomy of the babies, they felt able to care for.

Activity days criteria should be 500, and the Trust were having over 1000 activity days. Example – nearest unit for transfer was Grimsby, therefore, the service decided to keep the baby. If the baby only needed a short time HDU, the decision would be made to care for the baby rather than transferring out. This has impacted on the overall activity days for the service.

There was no expressing room for parents, however staff confirmed there is a plan with estates now the new move has been delayed.

The visiting team noted the following outstanding areas. There was a full time play therapist across sites, parent accommodation offered to all parents and the service was working towards BFI and Bliss gold accreditation.

Recommendations

10. The Trust should review the medical cover at the SJUH out of hours and appropriate escalation.
11. Perinatal peer review should support depth of cross directorate working in relation to teamwork huddles.
12. The Trust to review data around Neonatal Mortality, antenatal pathways and Saving Babies Lives v 3 (SBL) requirements.

6.10 Midwifery workforce

Maternity Matrons

The Maternity services substantive funded establishment for operational midwifery matrons is 3.9 WTE. The roles cover Community, Antenatal / Postnatal Wards and the Triage and Day Assessment areas, Outpatients/Specialist Midwives and the Labour Wards/Lotus. There is ongoing long term sickness in the team which has created further challenge within the team.

For an organisation that undertakes 9,000 births this structure is extremely lean especially given the dual site nature of the service. The Matrons report struggling with the oversight of large numbers of staff and a high workload. They are conscious of their limited ability to be present and visible in their clinical areas. There is minimal visibility and presence on the LGI site, with the lack of office space being reported as the reason to this.

The visiting team were particularly concerned regarding the wide responsibilities of the one part time Labour Ward/MAC matron. Due to the wide portfolio, they were unable to provide clear and consistent leadership across both labour wards. Labour Wards have a significant number of staff, complex equipment and provide high risk clinical care that requires focused and dedicated midwifery leadership. This dilution of the leadership then transfers to the Band 7 ward managers who have a significant number of staff to manage, clinical areas to oversee and leadership responsibilities. The team heard that this made the Labour Ward manager role unappealing to staff. This was escalated to the Trust Board at the end of the visit.

The service is managed by a small team of matrons four across both sites. This limited capacity makes it difficult to maintain consistent visibility on the shop floor, particularly given the need to cover both sites. Many of the matrons and senior midwives are required to cover a range of duties from overseeing patient flow and managing specialist teams to handling escalations and reporting. This often means splitting their time between clinical duties and administrative or oversight responsibilities.

The process of rostering the matron of the day is challenging because it must reflect real time staffing, levels of absences and the need to provide on-site support. Variability in staffing and constant shifting between sites can lead to gaps in communication and delays in addressing issues.

There is no formal succession planning or developmental programme for the Matrons, and the matrons described this as being needed. The senior midwifery team reported an element of silo working at matron/Specialist Midwife level which has been reported by both teams as

resulting in a lack of understanding of each other's roles and responsibilities and a cause of some conflict.

Ward managers

The service has dedicated ward managers/team leaders for the appropriate clinical areas. They have allocated management and clinical time within the rosters. They did report that they often are pulled from management time to support clinically and there was an increasing volume of Trust wide auditing and reporting (Perfect Ward) that they had to undertake that did not meet the specific needs of maternity. Staff were frustrated that the metrics that they had to report on were not reflective of maternity specific safety parameters.

Midwifery Staffing

The visiting team reviewed the documentation provided including the Birthrate plus assessment (March 2024) and the subsequent follow up papers.

The Birthrate Plus report identified a slight decrease in birth numbers, an increase in fetal medicine activity and a significant increase in the clinical acuity of the birthing population.

The report found a deficit in the clinical midwifery staffing of 28.64wte. The papers describe and in discussion with the HOM, there has been a clear plan to increase the midwifery establishment and apply a 90/10 split to the clinical midwifery calculation to include appropriate Band 3 MSWs to be included in the calculation. This plan was approved, funded and recruitment is progressing well. The service is on track to have minimal midwifery vacancies by the end of this year, however there are still consistent gaps within the clinical rosters.

Hospital v's Community staffing numbers

The Birthrate plus report (March 2024) identified a deficit in staffing of the hospital areas (LGI 22.17wte and SJUH 31.99wte) and that the community service was over established by 25.52wte. The visiting team discussed this with the midwifery leadership team. There appears to be a discrepancy in the views of the community midwives and the Birthrate plus report. Further work should be undertaken in relation to this. Caseloads, team size, working practices and workload should be assessed with a view to a staged move of midwifery establishment into the hospital setting in line with the B+ safe staffing recommendations.

The midwifery establishment has an uplift of 23% to allow for annual leave, training, sick leave and maternity leave. The Perinatal Services Information and Assurance Dec 2024 report explains the work undertaken to assess the required uplift. It was found that a 28% uplift would meet the needs of the service. It is understood that the uplift currently remains at 23%.

Maternity Leave - impact of unfilled shifts

There is detailed information provided that identified a clear pattern of a consistent average of 2.9%, around 18wte midwives on maternity leave at any one time. Although there an uplift exists in the establishment, this number adds to the burden of unfilled shifts in maternity. This could be alleviated by recruiting substantively into 18wte midwifery posts in line with other maternity services. There would be no cost pressure as the additional funding is in the uplift.

Recommendations

13. Due to the two large sites the Trust should consider increasing the midwifery leadership team by 14.45wte as recommended by Birthrate plus in March 2024. Consideration should include an additional HoM and DHoM and an increased Matron team to provide site specific leadership. An options appraisal has been produced and presented (Nov 2024), but it was not approved. This should be reconsidered to increase the quality and safety of the services.
14. An additional Labour Ward Matron appointment should be prioritised. This was suggested during the Trust Board feedback.
15. The community midwifery staffing establishment should be reviewed to align it towards the Birthrate plus recommendations. Consideration could be given to building an enhanced Continuity of Care (CoC) team due to the demographics and the local populations needs. A further consideration could be to support and improve areas in the inpatient settings such as Elective Caesarean Section (ELCS) staffing and flow coordinators. This will in turn change the planned roster numbers and give a more accurate reflection of fill rates as an indicator of safe staffing levels.
16. The Trust Board should consider the approval to proactively recruit into the current maternity leave average i.e. 18wte Midwives to maintain the required fill rate on clinical rosters.
17. The DoM role should be advertised substantively in the next 3 months to provide stability to the services. Given the scale and challenges of the service, the

appointee should have significant midwifery leadership experience. The role should align with the RCM and RCOG leadership recommendations and not include any other clinical services other than maternity and neonates.

18. When planning the future Midwifery Leadership Structure there should be consideration of the leadership capacity of the DoM. Either the DoM role should change to only include leadership of Maternity, or the HoM and/or Dep HoM numbers should increase.
19. The Labour Ward establishment and roster templates should allow for additional midwives to be rostered when ELCS lists are running to avoid cancellations and escalation.
20. There should be ongoing discussion regarding the appropriate staffing uplift for the midwifery establishment.

ELCS Midwifery staffing

The service runs a full day Elective Caesarean Section list 5 days per week. The lists run on different sites each day. The visiting team heard that currently depending on available midwifery staffing, during the planned ELCS lists there can be reduced numbers of the midwives on the Labour Ward as they are allocated to run the ELCS lists. There is work underway to ensure that there are clear dedicated midwives to staff these lists and not to reduce labour ward midwifery staffing.

Inpatient area staffing

The visiting team reviewed the midwifery and support staffing of the hospital ward areas. Currently agency midwives are being used in the postnatal ward areas to fill rota gaps.

There is oversight of the staffing rosters and metrics are reported to Trust Board. It was noted that compliance with one-to-one care in labour and supernumerary Labour Ward coordinator was good. The senior midwives were able to describe their planned staffing and were aware of areas for improvement. These included plans to-

- Equalise in and out of hours ward and Labour Ward staffing
- Have clearer plans for the staffing of ELCS lists
- Improve staffing to reduce delays in Induction of Labour.

The reported roster fill rates are generally above 90%. However, this is based on the current roster templates. It should be noted that the Birthrate plus report identified that LGI and SJUH inpatient areas were short of 22.17wte and 31.99wte midwives respectively. This

means that although the reported fill rate appears good, the planned roster numbers are below the safe recommended staffing levels. This was identified by the CQC and monthly reporting takes place.

The visiting team were struck by the flexibility of staff in moving from site to site. This is commendable and allows for flexibility of staffing and enhanced team working.

Retention saw a peak in 21/22 and went up to 10% turnover now 6% with 1.9 WTE per month stress and anxiety is the leading cause of sickness

Labour ward coordinators

There were labour ward coordinators on every shift but did describe on occasion having to provide clinical care on occasions of how acuity and activity due to there being no clear robust escalation process.

Community midwifery

There are currently 28 community teams with the support of 13 Maternity Support workers (MSW). Teams are geographically and largely GP based with a few teams working from Children's centres or Community Centres

Those based in GP surgeries have no base to meet at but use zoom meetings in the morning to allocate work. Shifts 8-6 or 9-5. There is no on-call rota. There are 3 Team Leaders and 1 Matron

There are also 4 specialist Teams that provide AN & PN care only

- Perinatal Mental Health
- Haamla Team – any vulnerability identified at booking – asylum seeker, DV, FGM
- Teenage Pregnancy
- Multiple Pregnancies – St James's

Staff reported that the support of women for whom English is not a first language are challenging. Since the pandemic it is unusual for them to use face to face interpreters. They have access to language line, but it doesn't not guarantee a female interpreter. This has been escalated to the CSU governance meeting.

Antenatal care is provided in clinics. Appointment times were considered appropriate unless translation is required and there is little time for administration follow up. All midwives have phones and laptops but battery life on laptops is inadequate and often leads to notes being

completed at the end of the day. Charging laptops is problematic. Digital notes have improved, and staff appreciated the development but there is still basic referral and functions that need to be developed.

Postnatal Care is provided through a mixture of PN clinics and home visits (50:50). Telephone assessments are also used. Women have allocated times in clinic but it is not possible to plan for home visits. Staff reported good relationships with Health Visitors and had a crossover 10/14 days.

Maternity Support Workers_13 WTE that work in the community, but not all Teams have an MSW but shared daily if needed. They are a valued members of the community teams and provide breastfeeding support. weights and re weights, Newborn Blood Spots if consented by a midwife, follow up of DNA's, phlebotomy, 36-week BF home visit with support for colostrum harvesting.

The Home Birth Team is based in the hospital, If women request a homebirth 50:50 estimated chance of this being available due to the home birth staff supporting the clinical areas.

There were lots of variation in relation to number of staff, caseload numbers, safeguarding and vulnerable numbers, this information was not readily available to maintain oversight of women using the services and there health requirements.

Community midwives have no on call responsibilities, limited time for postnatal home visits some caseloads were described as more than 140 women and there was no clear escalation process in place to maintain oversight of this and ensure that caseloads were equitable and manageable.

Recommendations

21. A clear understanding of caseload numbers, safeguarding, complex pregnancies would provide a better oversight of the services and staff and service user requirements
22. Review community midwifery services to ensure that they are correctly resourced by Midwives & MSW's. This should also include a review of Interpreting services, estates, IT and consider enhanced CoC teams.
23. Interpreting services should be reviewed across the service to ensure that they are fit for purpose and serve woman and families. Local resources created within the Trust should be reviewed and where possible used to support women with specific needs.

6.11 Home birth services / birth units

Home births and births at the Lotus Midwifery Led Unit (MLU) at LGI are covered by the Lotus team. This should consist of 2 RMs per shift, based on delivery suite at LGI, Home birth kit is kept on Lotus MLU and transported by midwives in their own cars. Staff reported that there is often only 1 Lotus team member on shift and if called to a homebirth, delivery suite will try to support as second midwife. Staff reported that it is not uncommon for homebirth service to be suspended and labouring women to be asked to come to the hospital because of staffing. The current homebirth rate is 0.5%-1%. It would be beneficial to have oversight and reporting of suspensions to the home birth services and the reasons why and how women are informed of this and the choices that they are then offered. This would then inform the community review as to what is required to continue to be able to offer choice to women.

6.12 Sonography

Meeting the scan timeframes in line with Saving Babies Lives was a challenge this was further impacted, due to not having enough of the right equipment in DAU/MAC as if there was not enough Dawes Redman CTGs, then women would be booked for a scan. There appeared to be little joined up working and meetings to oversee targets and identify risks. The service provision and collaborative working with the maternity services should be explored further to gain a depth of understanding how the two services align.

6.13 Specialist midwives

Although specialist teams exist to support areas such as midwifery, digital systems and patient flow there were several staff that were working off site the reliance on off-site working for some roles raises concerns about the practical ability to intervene swiftly in critical situation, particularly when rapid staffing adjustments are needed. There is also a perceived disconnect between nonclinical roles and the day-to-day challenges experienced on the floor.

When assessing the needs for additional roles, it is important to consider national reports such as Ockenden (2022) and the RCM leadership manifesto to ensure the requirement to have the same core specialists and managerial roles across all maternity units in line with such recommendations and guidance. The specialist midwives. roles are critical to core quality and safety to meet local needs, service user expectation and national requirements. in relation to providing ongoing assurance and leadership. There are several roles within the current structure that could be reviewed as part of an ongoing workforce and establishment review.

The review Team met with 12 of the clinical specialist midwives across the range of specialties including preterm, perinatal mental health, diabetes, teenage pregnancy, Haamla (caring for a range of vulnerabilities), maternal medicine, infant feeding, public health, multiple pregnancy and sonography. There are 14.32 WTE B7 specialist midwives and 8.29 B6.

Most community specialist midwives provide continuity of antenatal and postnatal care for women in the area in which they specialise. They also work to embed guidelines, pathways and increase the knowledge to empower all staff to provide safe and effective care for the different groups of women. They report good MDT working relationships and feel empowered to develop their services and are valued by colleagues. They work with the Practice Educators if there are safety messages that need to be embedded into practise. Email is used to support staff to development.

The specialist midwives provide quarterly highlight report for the subspeciality governance meeting (community and outpatient, intrapartum and wards) and escalate to women's quality and safety committee.

Most midwives had completed the Leeds Quality Improvement 3-day training but reported that finding time away from face-to-face clinical care was very difficult, particularly in the last 6 months. Midwives were connected to networks nationally and locally. There were examples of teams that were nominated for awards, show cased their work and were involved in open days for recruitment.

Recommendations

24. The Trust should review the specialist midwifery requirement against current establishment to ensure that the service has the right staff to provide the quality and safety agenda to support women and families' cross site
25. The Trust should review current agreed remote working arrangements to ensure that staff are able to respond in a timely effective and efficient way to provide support when required in critical escalation.

6.14 Consultant midwives

There is one consultant midwife to cover the entire service, the role is focussed on Public Health, social complexity working group, part of the public health equity network, maternal healthy weight, smoking working group, works closely with the ICB, looking at health issues within the local demographics. The consultant midwife also leads the birth reflections service which was a significant part of her current role. The consultant midwife is well connected

across the system and described many examples of partnership working. The work that was presented to us was exemplary. However, consideration should be given to appoint another consultant midwife with a different portfolio that could strengthen the quality improvements and experience for women, this will also provide cross cover in times of annual leave, sickness etc.

6.15 Fetal surveillance midwives

There are 2 site specific fetal monitoring midwives but described supporting clinically in times of escalation and cover 1 planned shift a month as part of specialist midwives providing clinical shifts. The roles are split with 1 WTE at LGI and 0.5 WTE at SJH. Training is combined cross site and there are 2 MDT training days per month. They work closely with the clinical education team to coordinate the days and ensure MDT attendance. there are also challenges with resources with no simulation suite or equipment.

The obstetricians are involved in the fetal monitoring study day, and they have 0.5 PA per site. They incorporate learning in action onto the agenda and link in with the obstetric consultant who is the lead for governance. There is a quarterly newsletter to disseminate learning.

The preceptorship midwives had a 2-day session on fetal monitoring and new obstetricians are provided with a brief update and then booked onto the mandatory session.

6.16 Screening coordinators

The screening coordinators were based on the SGH site, when we met the team, they described feeling overwhelmed by the workload. The team meets the standards set by the National Screening recommendation. The screening lead could clearly articulate the key performance indicators and where areas of improvement could be made. The screening provision could be further explored to ensure that the relevant resources and failsafe measures are in place for the size of the service.

6.17 Safeguarding

There is a named midwife for safeguarding who is part of the corporate nursing team the visiting team were not able to meet with all the safeguarding team and would be happy to explore this further.

6.18 Clinical Educator Team

There are x2 Band 7 midwives for both sites. They have a team of band 6 midwives who they manage. 2 WTE and 4 part time band 6 midwives.

Training oversight is provided by the Band 7 midwife and reported monthly to the LMNS and quarterly via the maternity governance meetings.

The band 7 works closely with the obstetric roster lead and roster managers for the midwives. There is a neonatal resuscitation officer who is based within neonates.

There is an MDT PROMPT team including neonates, obstetrics and nursing and midwifery. Venues for PROMPT training is limited as there can be 30 members of staff on one day.

- x3 Obstetric PROMPT leads
- x3 Anaesthetic PROMPT leads
- Theatre and nursing leads

There is ad hoc training simulation in the ward areas and staff couldn't articulate when this last took place.

Recommendations

26. Review the TNA to ensure that it covers all the mandatory requirements and encompasses a safety and learning update.
27. Review how the education team, PMAs, fetal monitoring leads link into incident review and complaint processes.
28. Review how compliance is monitored and escalated.

6.19 Bereavement midwives

The bereavement service is led by two bereavement midwives with just under 2 WTE capacity. The focus of the two excellent bereavement midwives appears to be more on post-discharge support and subsequent pregnancies than the acute in-hospital service.

This is significantly below the staffing level recommended by the Bereavement Midwives Forum of 1 WTE Bereavement Midwife for every 2500 live births.

Leicester, by comparison, with similar size and complexity has a significantly larger team providing specialist coverage seven days a week – 3.5 WTE spread across 4 x AfC Band 7 bereavement midwives and 1 x AfC Band 3 specialist bereavement support worker working 30/26/26.5/27.5 and 22.5 hours respectively.

There is no formalised seven-day bereavement service, and the service currently relies on goodwill and workarounds from the bereavement midwives. The Trust have declared compliance on a seven-day service; however, Labour Ward co-ordinators having done online

SANDS training does not equate to a bereavement service. The Bereavement Midwives advised that they do have support from a small number of 'bereavement champions', but that their capacity has recently been reduced. There is absolutely no guarantee of a 'bereavement champion' on every shift.

Rainbow Clinic at LGI appears to be held in the same antenatal clinic as other antenatal services, and consideration could be given to relocating this service to a different part of the hospital to minimise trauma to families, as is standard practice at St. Mary's Hospital in Manchester, where the original Tommy's Rainbow Clinic is located. There, instead of the main antenatal clinic on the ground floor, Rainbow Clinic is run on a Thursday out of the research department on the fifth floor

The impact on families is pronounced and the experience of care feels personalised, and all other families sat with you in the waiting area are there for the same reason, which mitigates unintentionally insensitive communication from other service users.

There is a dedicated room within the antenatal clinic at LGI for breaking bad. We were informed that women receiving bad news within the triage area would be delivered in one of the clinical consulting rooms behind the midwives' station which does not provide a sensitive and personalised approach to breaking bad news.

Notification and Handover Processes

Bereavement midwives receive notifications via K2, Embrace, and verbal updates from teams. Systems to proactively track cases (e.g., routine K2 reviews, liaison with labour ward coordinators) appear relatively strong but dependent on staff initiative. Limited clarity on formal out-of-hours pathways, particularly between diagnosis (e.g. Intrauterine Fetal Death) and admission. There were some inconsistencies in who notified families about available support and when that happens.

The 'Handbook for Bereaved Parents' leaflet that the Trust has produced (2023), written not by a specialist bereavement midwife but by one of the Senior Leadership Team, should be prioritised for an urgent review. The visiting team understand that it was 'shown to the MNVP' but not co-produced with service users with lived experience of the death of their child.

The practical elements that are being communicated put a disproportionate responsibility on the family to make their own arrangements at exactly the moment in their journey where they need the service to catch them and carry them through. Much of the language is clinical and often makes assumptive statements about the care that will be received.

The order in which the information is laid out is disjointed and doesn't always flow entirely logically in terms of the order a family might need the information it contains. Much of the advice provided within it is significantly outdated and does not reflect current best practice in terms of the bereaved parent service user experience. For example, when suggesting things a family may want to bring into hospital for their baby, it simply states "Clothing, Blanket, Cuddle toys or teddy" this should form part of the review to ensure that parents are understanding of what to bring which is significantly more extensive.

Postmortem consent and PMRT

The presence of a dedicated postmortem consent nurse is a strength, though visibility and integration with wider care pathways is inconsistent. There is a risk that an additional individual coming into the space for that one isolated interaction makes circumstances harder for families who need a circle of trusted professionals around them.

Staff raise concerns about ensuring postmortem consent remains a compassionate clinical process, not a technical administrative task. Weekend coverage remains a pressure point, risking delays in time-sensitive processes. PMRT family feedback is routinely gathered, but not all families are aware of how to input into reviews or follow up if they disagree with grading. Only rare examples of families requesting to attend PMRT; practice is not fully standardised across teams.

Bereavement midwives acknowledged that their capacity to deliver acute in-hospital care is limited due to the challenges of other commitments, such as the Rainbow Clinic and home visits across the city, meaning that this care (including vital elements like memory making) is delivered inconsistently and not effectively audited for quality.

Memory Making and Choice

Memory making offers include memory boxes, clay imprints, 3D casting, and photography (e.g. via Remember My Baby). This service is inconsistently offered and provided, for example, there are neonatal staff at St. James' who are experienced in 3D casting, but that offer is not routinely made to families in maternity as it depends on the availability of those neonatal staff to facilitate it. It is unclear whether this service is offered to families at LGI at all or not. The visiting team have offered to make further introductions to the team at Little Cloud, the charity the neonatal team use for their 3D castings, as they are friends of mine.

The visiting team have provided the bereavement team with some supplies of a newer form of clay that enables softer imprints to be made into a clay that is not at risk of being broken or cracking and given them the link to the supplier of this.

Upskilling midwives on both the practical delivery of memory making opportunities – how to do hand and foot prints well, how to get the best clay imprints, how to take photos on phones, etc. are absolutely critical, but just as critical is upskilling midwives in how to approach these conversations confidently and compassionately, and how to best facilitate families having the opportunity to participate in their own memory making, rather than having memories given to them. BMs explained the challenges in trying to run effective training sessions to improve confidence and skills for staff in delivery of bereavement care. The SUV in the visiting team has offered to support this.

Offers for memory making are inconsistently re-visited, risking missed opportunities for families who change their mind. There is no formalised policy for routinely offering repeat opportunities throughout the hospital stay.

Families are not always offered the option to escort their baby to the mortuary or to take their baby home. One of the challenges here is a fear around doing this in a way that feels compassionate and appropriate both for the family involved and the wider public in the hospital the visiting team can provide support and options to overcome this to enable more options being offered to parents.

CuddleCot use supported by local hospices, the team heard that the Trust Standard Operating Procedure (SOP) on taking your baby home is stalled in governance. The Trust has multiple CuddleCots but apparently no cold cots, exacerbating challenges in estates.

Staff members on delivery suite at LGI expressed lack of confidence in delivering care to bereaved parents and said it tended to be left to certain individuals to do this in turn creates potential for single points of failure if those members of staff are not present (see above re: training). When the team asked to see a memory box, the delivery suite midwife at LGI produced one of the smaller memory boxes more commonly associated with earlier gestation losses, which suggests a lack of confidence around knowing the finer nuances of bereavement care, something that she herself readily acknowledged.

Environment and Communication

There are significant challenges with the estates and general appreciation of what's appropriate for families. In the Grace Ferguson Room in antenatal clinic at LGI, we found 3 blood pressure machines, suggesting it was being used, at least in part, as something of a storage area. This is inappropriate and was quickly resolved by the Deputy Chief Nurse, but the underlying issue is that it speaks to the mindset and consideration given to what this room represents and is used for. On the wall in this room was a poster advising service

users to ask if they hadn't been offered an amniocentesis which is not a poster you want to see in a room where you've been shown to be told that your baby has died.

The Rosemary Suite at LGI is accessible via a separate entrance, so families do not have to go through the main delivery suite to access it. This is positive and is in line with National Bereavement Care Pathway best practice. However, the route families use to access this entrance amounts to a service corridor, the visiting team noted that this was dirty, with large clinical waste bins in the corridor. Much consideration is needed to service user experience and how marginalising this will feel. Feedback from Bereaved parents from Leeds spoke at length in conversations about the negative impact of that corridor. We understand that the bereavement midwives had been trying to have these clinical waste bins removed, and that since the MSSP Diagnostic visit this has happened. A coat of paint and some consideration would work wonders for this hidden part of families' experience. A bereaved family wanting to access the water birth facilities would have to go through the whole of delivery suite to the opposite end.

In the Rosemary Suite itself, almost all the drawers were filled with clinical items. The room had been decorated nicely, but there is definite room to improve the experience and the feel of the suite. We were only able to see one of the two bereavement suites, as the other was in use. On the wall, there was a leaflet holder, the only leaflet contained in it was the Miscarriage Association's leaflet about Pregnancy after Loss. This is a wholly inappropriate leaflet to have out in that environment, compounded by it being the only leaflet in the rack. In addition to the inappropriate nature of leaflets from the Miscarriage Association in environments likely to be disproportionately accessed by service users who've experienced a stillbirth, the leaflet opens by listing all the emotions people are likely to experience in subsequent pregnancies:

- Strong feelings of anxiety that start as soon as you have a positive test but a long time before you can get any support from healthcare services.
- Moments of overwhelming anxiety or panic.
- Struggling with physical symptoms like sickness, exhaustion and painful breasts – finding them hard to cope with but fearing the worst if they ease.
- Feeling unable to trust your body.
- Finding it difficult not to start checking due dates and imagining the future while keeping your expectations very low.
- Living on high alert, for example checking for blood whenever you go to the toilet and fearing any feeling of wetness in your underwear.
- Dealing with grief for your previous loss or losses alongside fear and hope for this pregnancy.

- Feeling guilty or worried about forgetting your lost baby or babies.
- Having a different pregnancy experience to others and feeling isolated as a result.
- Having a strained relationship with family and friends because you find it difficult to cope with positive or excited reactions.
- Not wanting to tell people in case things go wrong but finding it difficult to manage without their support, whether at work or with family and friends.
- Feeling sad you feel this way or as if the joy of pregnancy has been taken away from you.
- Feeling isolated and unsupported if specialist care you had before pregnancy (for example, during fertility treatment) does not continue now you are pregnant.

There is absolutely a place for this leaflet – antenatal clinics and Rainbow Clinics, not bereavement suites.

This suggests a lack of diligence in both considering what's appropriate and in keeping these facilities stocked again, not on the part of the Bereavement Midwives, who are being pulled in multiple directions, but on the part of the wider team, suggesting a capacity and skills gap on delivery suite. The suite isn't soundproofed but is through some double doors and therefore it would appear that is relatively protected from the noises of a busy delivery suite.

The bereavement suite at St. James's (there were two, there is now only one) can also be accessed via a route other than through the main delivery suite. It has an incredibly clinical feel to it. It would benefit from a Murphy bed that can be put away to enable a clinical delivery bed to be brought in and out as indicated.

One long wall is overwhelmingly windows, and during the afternoon I was shown it (in mid-March), it was stiflingly hot. Given that the hospital only has supply of CuddleCots, not free-standing Cold Cots, this presents a very real issue around the deterioration of a baby's body in warmer months. CuddleCots will disproportionately cool the part of the baby's body that they are in direct contact with, and so would not prevent severe and rapid deterioration in the summer. This absolutely presents a risk for service user experience, but also could potentially compromise the effectiveness of a post-mortem in some cases, depending on how long a family wanted to spend with their baby.

Urgent consideration should be given to the purchase of some Cold Cots (such as the ones provided by the charity Abigail's Footsteps as well as other suppliers) and installing air conditioning should absolutely be considered. Spending extended periods of time in that

room during warmer weather would be a deeply unpleasant physical experience for families in addition to everything else they're going through.

The room is not soundproofed and there are no plans to do so, the visiting team shared examples from other units such as Berkshire Hospital in Reading who could not easily soundproof their bereavement suite and therefore, they placed images on the outside wall (in the corridor) just like the ones at St. James's, but with reinforced special material that acted as a noise reduction measure. They had also installed a white noise machine in the bereavement suite itself to enable families to control their exposure to external noise from within the suite. These are the sorts of innovative approaches that can make a spectacular difference to families in hospital environments where challenges with estates make more wholesale change next to impossible.

Personalised Care and Equity

There was a strong focus on personalised care from the bereavement midwives (e.g. home visits, flexible contact based on family wishes). Midwives often demonstrate high levels of compassion, adaptability, and continuity in practice; however, equity gaps remain based on timing of loss (e.g. weekends), location (St James's vs LGI), and availability of bereavement champions.

Memory making and choice can differ depending on staff confidence or capacity, which risks compounding trauma.

The bereavement midwives in this Trust are clearly deeply compassionate and deeply committed but simply do not have the capacity to deliver the improvements, or even the basic consistency of the service that they themselves clearly recognise is needed.

Recommendations

29. Define and implement a seven-day bereavement support model with clear escalation and out-of-hours protocols.
30. Consider Increasing staffing to at least 3–4 WTE bereavement midwives and/or support workers to meet demand across both sites.
31. Standardise bereavement champion training and Rota presence to ensure every shift has a confident, capable staff member available.
32. Finalise SOPs for families taking babies home, including hospice liaison, cuddle cot governance, and police notification guidance.

33. Re-write the trust's Handbook for Bereaved Parents, new version co-produced with service users with appropriate knowledge and/or lived experience and consider when and how this leaflet is provided, as well as how the arrival-in-hospital services it describes are delivered.
34. Implement a bereavement suite environment checklist and ensure materials (leaflets, posters) are regularly reviewed and curated.
35. Ensure memory making offers are revisited regularly throughout the inpatient stay, and that memory-making options are consistent across sites.
36. Work with service user representatives to co-design and participate in staff training, simulation, and QI initiatives.
37. Clarify family involvement options in PMRT processes and offer routine debriefs and explanation of grading where appropriate.
38. Address corridor aesthetics and privacy issues near bereavement suite entrances and consider user-led walkarounds as part of improvement planning.

6.20 Professional midwifery advocates

The professional midwifery advocate (PMA) team is lightly staffed. There is a lead PMA, however, she has very little time allocated to undertake the role. The 1 x WTE role is split between PMA and pastoral support for students and midwives with 1 lead undertaking the 2 roles. There is not a specific number of hours per week per role and flexes the time between. The monthly data activity is completed by the lead and reports this information to an administrator, who is not working in maternity, but a trust corporate administrator. There are 24 trained PMAs between the 2 sites. Only 4 are allocated any dedicated time to undertake their PMA activities, most are non-sessional. The time allocated can vary between 2 or 3 sessions per month across both sites. Currently the workload of the units has meant that they often get drawn into clinical work as part of escalation, leaving minimal if any PMA allocated sessions.

The ratio of PMAs to midwives is 1:20 however in practical terms it is a lot less. PMA's do not get a separate uplift to their salary to undertake the role and are expected to complete in their allocated hours. There is no specific succession plan or external training in the pipeline for any new PMA's and no active recruitment is taking place. There is corporate in-house training available for Professional Nurse Advocates (PNA's) and the lead PMA works closely with the trust lead PNA.

None of the E learning for health modules have been shared with midwives to allow them the opportunity for further training to consider undertaking the role in the future.

The PMAs are available for student midwives and support workers should they be needed and there are good links already with the university of Leeds, which has 5 PMA's.

PMA quality improvement work includes an autism support working group to give additional support for staff with neurodiversity, working with staff who are on long term sick leave, maternity leave. There is reported to be minimal involvement in other projects.

There is a regular update e mail sent out from the lead PMA to the main PMA group every month. They are trying hard to promote the role, with business cards, posters and surveys. There is also a trust wide "roadmap to professional advocate practice" document that has been produced, to support newly qualified advocates, including midwifery and nursing.

Most of the workload for PMAs is for staff restorative supervision in 1-2-1 meetings and occasionally having career conversations on an ad hoc basis. They also attend rapid reviews as part of the PMRT process. They do not have a role in listening clinics or birth reflections with service users.

Access for staff to the PMA service is via a separate roster which is circulated by e mail. There is also a single e mail address for the service and a QR code with a direct link to the address available on posters throughout the unit. There is a booklet explaining the service which is distributed to staff.

A staff survey has recently been circulated, with over 70 responses. This has recently been analysed showing a relatively poor response rate of just over 11%. (70 responses from 629 staff). From that 11% only 33% have reported that they have accessed a PMA. Of those that did, they found the support to be empowering and compassionate, they felt validated, and reported the discussions were tailored to their individual needs.

Each PMA has a national PMA badge, and they work collaboratively with their PNA counterparts in the trust.

The lead PMA was not aware of a regional lead PMA but does try to attend the regional PMA network meetings, however, has not been able to do this on the last 2 occasions due to clinical need and workload. None of the PMAs have attended the annual national online conference and have not accessed the NHS futures platform.

The dedication and enthusiasm of the PMAs was noted and obvious during the discussions despite being such a small team. The main challenges were reported to be gaining wider staff buy in to the service, currently staff morale is low and the availability of the PMAs due to clinical workload.

It is understood that the current moulding of the service has been formed by restrictions imposed by circumstances, media attention and a general lack of understanding of the PMA service.

Recommendations

39. Support the development of the existing PMA service by ensuring all the midwives who have trained as PMAs have enough allocated and dedicated time built into their rosters to facilitate meaningful interaction with staff this could be encompassed as part of the establishment review.
40. Senior midwifery managers should share and discuss the results of the recent PMA survey of staff and encourage further promotion of the service.
41. The Trust should consider improving the visibility of the PMA team and service which will benefit the staff.
42. Ensure the lead PMA can liaise with the regional lead PMA which will enable innovation within the services.
43. Consider a lead PMA role that can focus solely on PMA activity.
44. Expand the team of PMAs: plan the recruitment and development of future PMAs in line with robust TNA.
45. Involve the PMAs in all QI work across the division with improved accountability within the department and across the Trust
46. Team coordinators to fully understand the role of the PMA and encourage greater autonomy of the group
47. Consider celebration events for PMAs, staff to involve women and families.

6.21 Student midwives

Student midwives describe overall a positive experience but also described being utilised in the numbers occasionally when there was short staffing. There are opportunities for 3rd year students to hold their own breast-feeding clinics, etc. examples can be provided from other units.

There is a centralised recruitment programme across West Yorkshire where students put down their top 3 choices which has reduced the number of students not taking up a place when offered due to applying to more than one organisation

The visiting team met with a selection of 1st, 2nd and 3rd year students. They rotate between both sites and do 1 year and then have a choice. There are 80 students split into 2 cohorts, and they described a disparity between what the university expected them to achieve and what they could achieve in their placements. They all agreed they would like more exposure to emergency scenarios and a more structured approach to dealing with these. They do attend PROMPT and are planning to do this with the medical students moving forward.

They reported that some midwives were reluctant to supervise them with their NIPE examinations and sign off in practice could be difficult. The midwives had reported to the students that they found the use of the pebble pad problematic if there was a shortage of computers to use in the ward areas.

They have a Practice Placement facilitator who they said was very helpful. The Midwifery apprentices work on the opposite rota to the student midwives.

The students mentioned that the midwives rotate with them too and that can make it difficult to raise concerns about midwives if needed, as they cannot retain their anonymity, and this could affect the mentorship relationship.

One of the students raised an issue about not feeling listened to in relation to an incident. They described how the PMA and lecturers were easier to raise concerns with. A student midwife said he had sought advice from his practice supervisor in these cases.

The students reported that the MAC – triage always appeared understaffed, and staff were consistently moved to support safe staffing on delivery suite.

They described a good experience in both units but there was some reference to small groups of staff who were territorial. The Band 5 rotation is between all areas, but they are constantly moved due to staffing. Students had witnessed inappropriate discussions in open areas, about individual staff members. They mentioned that the ODP theatre staff and MSW were particularly poor at this.

Bereavement training was another issue raised as the students felt that the midwives were unsure about the systems and process to underpin compassionate care which in turn made the students anxious about caring for a bereaved family.

6.22 Preceptorship lead / Recruitment and retention

There is no dedicated preceptorship midwife, the role of the preceptorship lead is critical to the support and development of new registrants. A robust preceptorship programme attracts and retains midwives. the visiting team were informed that the vacancy rate was low, however agency midwives were still being utilised and fill rates were not demonstrating

Recommendations

48. The Trust would benefit having a quarterly review of recruitment and retention performance to maintain oversight of attrition rates and which may enable earlier intervention.
49. An established funded role would be beneficial in supporting ongoing recruitment and retention
50. To understand current vacancy rate and triangulate with the reported fill rates.

6.23 Maternity support workers

There is a need to have support staff to support maternity wards, outpatient clinics and community services. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method. There is a mixture of band 2 and band 3 MSWs working across the unit at LGI. MSWs reported to our team that they were given the choice to work towards their band 3 and some have chosen not to do this.

6.24 General management

The general management team for the CSU consists of a general manager for all administrative staff and has delegated responsibility from the clinical director to oversee and manage all areas of performance in the CSU, across finance, human resource, and quality and safety.

There is a business manager who reports to the General manager who has oversight of the budget, workforce, quality and safety relating to administrative staff in obstetrics. There are also two services managers, one for obstetrics and one for gynaecology who report to the General Manager.

6.25 HR support

Staff reported that there were several ongoing HR processes, and that more HR support would be beneficial to ensure streamlined processes that support staff and the service.

7. Clinical services

7.1 Planned caesarean section

The visiting team heard of concerns and anxiety regarding the availability of Cell Salvage on the LGI Site with cell salvage not always available and women were then having to be transferred to the SGH site for delivery, this issue was highlighted by midwifery, obstetric and anaesthetic and theatre staff. There was a theatre team available, and scrub was provided by main theatres.

Recommendations

51. Actions should be expedited to ensure that the is 24/7 availability of Cell Salvage for Maternity Theatres at the LGI. Either by allocating a specific machine to maternity (with the appropriate maintenance and checking in place) or by ensuring there is a wider pool of machines available across the site.
52. Staff should be encouraged to report any incident relating to Cell Salvage availability. This should be monitored and reported up to Trust Board.
53. There should be regular feedback to the Board Safety Champions regarding progress with this concern.
54. This Clinical Risk does not appear on the Obstetric Risk Register Report (17/3/25). Consideration should be given to undertaking a Risk Assessment and escalating this to the Risk Register.
55. Review consent process in line with service user feedback

7.2 Induction of labour

The visiting team were introduced to several MDT members to discuss the induction of labour (IOL) pathway and were also provided with the IOL guideline.

Staff reported a high level of delays in the induction of labour pathway at LGI. The top two reported incidents on the antenatal ward were related to delay in transfer to delivery suite for ARM and women not receiving one to one care following ARM on the ward.

7.3 Triage

Currently maternity triage is located within Maternity Assessment Centre (MAC) at LGI. This area consists of a reception area, an assessment room behind the desk and a bay. During our visit the intercom was not working, and the staff reported this had been an ongoing issue, as well as this the CCTV was broken, and this had been an on-going issue. There was a sign on the entrance door to ask service users to call a number to gain access or to go to another ward and they would let them in, this meant people walking through antenatal ward

to access MAC. This sign was in English and in an area of limited phone signal. Staff expressed frustration at continuously escalating these issues and not receiving a response. After escalation by the MSSP team this was fixed on the last day of our visit.

The triage policy follows the BSOTS pathway, during our visit we spent time in triage observing and talking to staff. They confirmed that they are not currently following BSOTS. We observed that when women arrived and had their initial assessment, often they were not allocated a RAG rating. It was difficult to understand who was in the unit and what their clinical priority was. There was no set member of staff for initial 15-minute assessment or for ongoing care. The team reviewed the electronic system during the visit and discussed with staff the process they follow for admitting people onto the system and allocating them a clinical priority, there was not a consistent way of doing this meaning the data for breaches to triage timings was not robust or reflective of reality. There is an opportunity to review current triage staffing and training to support the proper implementation of BSOTS and enable robust audit.

Staff reported that they have been informed not to put in a Datix when there is a breach in triage due to delay in doctor review.

7.4 Telephone triage

Telephone triage at LGI is based at the reception desk of MAC (While the staffing template includes 4 RMs, 1 dedicated to telephone triage, this was not happening. During our visit we spent time every day in MAC and the phone was answered by whoever was available at the time. It was a busy, loud environment which provided no privacy for sensitive and personal conversations. When a woman is triaged via the phone and asked to attend MAC, her name, gestation and presenting issue is written on a whiteboard, this information is visible to other service users attending the reception desk. There is no time recorded on this board, so staff were unaware of when someone had called or what time they were expected to arrive. During our visit we noticed there was a woman on the board who had called with absent fetal movements, we asked when she was expected, and nobody knew. When they checked the computer system it was discovered that she had called 2 hours previously. The staff confirmed there was no policy in place for following up high risk non-attendance at triage. It was not clear who was who in staff as no uniforms were worn, other than theatre scrubs.

There is an opportunity to have a cross-site telephone triage which takes this away from the clinical areas and a space has been identified

Recommendations

56. Explore cross site telephone triage for consistency and improved access for women providing privacy
57. Review and relaunch BSOTS in collaboration with staff
58. Review policy for non-attenders to ensure that these women are contacted and offered a further conversation and to attend if required
59. Review current medical staff rota and availability to ensure that women are reviewed as per pathway and reduce the risk of an adverse outcome due to delays of obstetric medical review.

8. Neonatal

ATAIN

The visiting. Team heard that ATAIN reviews were taking place, however these were not MDT and obstetric attendance was varied. It was unclear how the learning was shared from these reviews.

Transitional care

Transitional care was in place on both sites with good systems and processes in place.

9. Clinical pathways

9.1 Estates

The estates at LGI are challenging. The maternity services are spread over 3 floors and signage is incredibly poor. The visiting team found it difficult to navigate, often ending up at the wrong entrance to wards even when following signs. The team undertook some walk throughs from a service user perspective, to navigate to MAC and to Postnatal ward which were challenging, we reflected if service users have limited English, or any learning needs it would be even more difficult to find their way.

At the St James' site the clinic was observed to be clean and staffed with sufficient personnel to provide support when needed. However, corridors were cluttered with numerous trolleys, creating a cramped and disorganised appearance. Various information posters were displayed, but some were outdated, contributing to confusion rather than clarity. Limited signage made navigation challenging, particularly between different units, reception areas, and key locations such as patient toilets. Space constraints compromised privacy and dignity, particularly in assessment rooms and shared ward areas.

The visiting team noted the poor signage and wayfinding regarding maternity services on both sites. We understand that this has also been highlighted by the MNVP. This is a potential safety issue and will affect the experience of families using the service.

The team were also stuck by the lack of identification of Maternity as a service within the organisation. In stark contrast is the clear welcoming signage and branding of The Leeds Children's Hospital on the LGI site. This issue is important not just in terms of wayfinding for families but improve signage will boost the pride and recognition of the maternity service amongst the staff and public.

LGI site the antenatal clinic is a significant distance from the rest of maternity, wayfinding was really challenging.

Recommendations

60. The Trust Communications and Estates teams should undertake work to bring the unique identity and wayfinding standard for maternity areas to the same standard as The Children's Hospital.

9.2 Specialist clinics

There were specialist clinics running at diffident sites that covered maternal medicine, diabetes. These were described as well embedded and provided a personalised plan of care for women with complex pregnancies

9.3 Fetal medicine

The Fetal medicine centre is located at the LGI site and managed complex pregnancies, it was unclear how the individualised care planning linked in with the neonatal team.

9.4 Birth reflections

This was undertaken by the consultant midwife and the service was still developing and would benefit from a robust SOP as having only one member of staff providing this service could be a single point of failure. There were ongoing frustrations around consultant availability to support some of the debriefs and the letters that were then sent to women explaining their experience. Given the challenges that the organisation face in terms of timely, open and honest feedback to women and families about their experience this is an area that should be prioritised to ensure this has adequate resources supported by a structured and supportive governance framework.

Recommendations

61. Review current pathways to strengthen the service
62. Oversight of the letters prior to them being sent to families to ensure a compassionate and proportionate response that is reflective of the lived experience.

9.5 Equipment

We heard from numerous staff about the challenges with equipment, the CQC had highlighted the need for more CTG machines during their inspection, this still hadn't been addressed during our visit and the bid that had been submitted had been rejected by the finance department. The visiting team saw CTG machines being moved between areas to try and accommodate women requiring urgent CTGs.

It is understood that currently there are around 8 machines based on the LGI site, however some are currently being repaired and there were significant delays in these being returned to the clinical areas.

Staff reported the resuscitaires and scan machines were out of date and were not supported by service contracts. There were no systems and processes in place to highlight this and

The matrons described how they had requested diaries for the community midwives, and these had been turned down due to the expense and to review a digital option.

Community midwives described frustration at not being able to charge their laptops in community due to the availability of chargers and outdated laptops. This impacts on the efficiency of community midwives providing a service and the additional travelling to the hospital to be able to connect and charge laptops to complete required documentation.

It is imperative that staff have the correct equipment to undertake their role. This is critically important to ensure the safety of mothers and babies, supports high quality clinical care, promotes timely decision making and enhance patient comfort and experience whilst supporting staff efficiency and morale.

Recommendations

63. The Trust should identify all vital equipment that requires replacing and develop a clear trajectory, risk assessment and mitigation plan. Ensuring that this is visible on the risk register

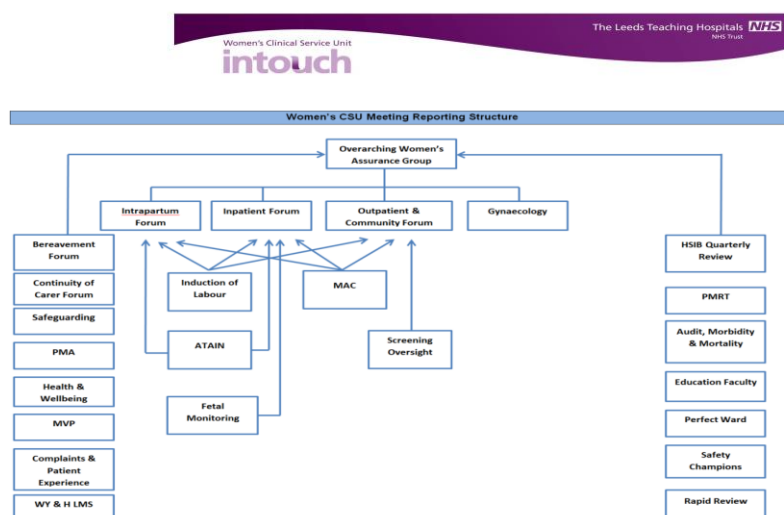
64. Ensure there is oversight of all equipment that needs replacing to maintain a clear trajectory for delivery.
65. The Maternity teams should be escalating risks to the Safety Champions for this to be raised at the Trust board. The roles of the safety champions should be reviewed to ensure clear roles and responsibilities and accountability to raise concerns.

10. Quality and Safety

10.1 Patient Safety Team

The team was led by a non-clinical member of staff at 8b, the structure of the team was extremely lean to cover both sites and the lead undertakes governance for the whole CSU. There was a challenge with visibility of the team with some remote working which can lead to a lack of responsiveness to clinical incidents, staff support and immediate learning. The meeting structure appears complex and after attending some of the patient forums, the agenda was extensive, and a more focused approach may provide more assurance and joint decision making. All the forums are chaired by an obstetrician and during staff discussions there was confusion regarding frequency, membership and purpose of the meetings. Various staff members reported that they had raised concerns at these meetings without clarity on next steps or feedback of actions. The role and effectiveness of the divisional governance meeting was unclear.

The governance team will undertake a review of an incident and there are 2 slots protected per week for a rapid review, team leaders will take feedback back to the staff in the clinical areas. Staff that have been involved in the incident are currently not currently invited to the review meetings to be able to provide an update of the incident.



Recommendations

66. To review the current structure to ensure there is the correct WTE to provide a robust, responsive and learning approach to untoward incidents.
67. There is an opportunity develop a communication strategy to promote effective learning
68. The development of a strong governance framework would be beneficial to be shared with all staff outlining roles, responsibilities and accountability.

10.2 Risk Register

The process for escalating risks and populating the risk register, was unclear and happened at the CSU governance meeting. Mitigations were unclear on risks that had been on the register for a period of time and it was unclear as to who agreed on placing risks on the register.

10.3 Safety training and learning culture

Creating smart actions and ensuring widespread learning which will lead to sustainable change is challenging with a large multiprofessional cross site team. There are many ways that learning is perceived to be shared, however not all staff are aware of this and cannot articulate key learning and changes in response to incidents, service user feedback and safety concerns. The golden thread of safety refers to a structured approach to patient care that involves clear communication, collaboration among healthcare professionals and a focus on continuous improvement to ensure safety at every step of the healthcare process.

There appears on over reliance on learning through e safety newsletter, there was no patient safety training included in the mandatory training programme which staff described would be beneficial.

10.4 Patient safety Incident Response Framework (PSIRF)

LTHT were an early adopter to PSIRF, the processes are not yet embedded within the maternity services and staff were unclear about PSIRF methodology when we spoke to them.

10.5 Guidelines / Audit

This was overseen by one of the governance team there were several guidelines out of date, and these were discussed in the appropriate forums and agreed and ratified. There was a robust audit plan and audits were completed by midwifery and medical staff.

10.6 Complaints

There was a complaints midwife who worked with the Trust complaints team. the process that was described to the visiting team did not provide assurance that the complaint responses were as compassionate or as timely as they could be. The process following receipt of a complaint is that the complains manager would e mail the complainant suggesting a meeting. This detracts and can make the complainant feel undervalued. There is an opportunity to review this process to be more patient centred and contacting the complainant directly to talk about their experience. Situations can often be diffused by actively listening to patient experience and providing an explanation of how this will be managed and fed back.

Recommendations

69. The Trust would benefit from reviewing the current complaint processes and pathways with consideration to contacting the service user by phone when the complaint is reviewed to promote a more compassionate and transparent response. Ensuring that the members of the team have had the relevant training to enable them to respond in a kind and compassionate way and changing the terminology to patient experience midwife rather than complaints midwife would all be a positive step forward.

10.7 Perinatal Mortality Review Tool (PMRT)

The coordination and responsibility for the PMRT is led by a member of the governance team. The PMRT meeting structure and service user engagement was unclear, and it was

described that there is little externality when reviewing cases. It was unclear as to how learning outcomes and changes to practice are disseminated effectively with ongoing oversight and audit that changes to practice and improving outcomes.

There was minimal service user input, and some staff described this as being distracting, which further demonstrates the culture of the organisation.

The bereavement midwives support parents through this process but described family upset and trauma at having to wait so long for any information around their baby's death. The feedback to parents could be vastly improved in a trauma informed way as the letters were dictated and were then translated which led to parents receiving a non-compassionate letter putting the lived experience on themselves and not the organisation.

Recommendations

70. The PMRT process would benefit from a full review to ensure that it remains service user focused, and that learning is able to be clearly articulated.

71. A review of the letters sent to families and how families want to receive feedback would be beneficial to ensure a compassionate and service user led approach

10.8 Maternity Incentive Scheme compliance

The oversight and monitoring of the MIS year 6 was unclear, the oversight sits with the HoM who presented a paper to the Trust board, there was no assurance of who had reviewed and signed off the evidence and the NED described not having sight of this.

The Trust have declared full compliance for the entire MIS reporting period.

NHSR / ENS/ MNSI

ENS - A thematic review of all cases reported into the Early notification scheme between 1 April 2017 and 2 October 2018 was commenced as it was identified the Trust had reported 26 incidents during that timeframe which was a higher number than expected

Themes identified from these are:

- Issues involving correct interpretation, categorisation and action for pathological CTGs
- Delivery not expedited at earliest opportunity
- Issues regarding the management of induction of labour
- Lack of support staff
- Issues regarding escalation management of syntocinon for augmentation of labour
- Lack of in-depth Trust investigations

- Ensuring investigations are embedded into practice e.g. audit / spot checks
- It was noted that there was a sole investigator in many cases

A further proactive review was commenced in May 2021 following feedback from MNSI regarding reoccurring themes

The themes identified during this review were:

Fetal monitoring

- Delayed escalation of abnormalities
- Misinterpretation and mis classification
- Delay in switching modalities (intermittent auscultation to CTG) when indicated
- Antenatal CTG interpretation using intrapartum guidance

Escalation of clinical concerns

- Delay in midwifery team requesting medical review in cases involving maternal pyrexia, fetal bradycardia and pathological CTGs
- Lack of progressive escalation to consultant when registrar was busy elsewhere, in cases involving pathological CTHs

Delay in delivery

- Lack of situational awareness in second twin delivery with deteriorating CTG trace
- Mismanagement of bradycardia
- Delayed category 1 caesarean (35 minute decision to delivery interval)

Loss of situational awareness

- Multiple contributory factors to poor outcome not considered due to lack of holistic review
- Duration of bradycardia
- Delay during breech delivery

During the visit some of these themes formed part of ongoing reported incidents. There needs to be more oversight and actions with ongoing themes to identify changes to practice or more focused education and learning.

It was noted during the visit that learning and reflecting from incidents could be significantly improved to ensure safety for women and families. The processes for engaging families in the review of incidents and including their experiences was not prioritised. The Trust were

aware this was an area that they needed to focus on and described a commitment to improving this.

NHSR have offered training to the Trust on several occasions, however, at the time of the diagnostic review there has been no engagement from the Trust to undertake this offer.

MNSI - Quarterly meetings have been held with MNSI leads and the LTHT leadership teams. There have been similar clinical recommendations with a formal letter of concern from MNSI which has since been closed. There are currently 5 ongoing cases.

Recommendations

- 72. It would be beneficial for the Trust to have complete oversight of themes of incidents to identify any trends to ensure the Trust is responsive to ensuring the ongoing safety of staff and service users.
- 73. The Trust should consider engaging with NHSR and undertaking the offer of training to demonstrate a willingness to continually improve services, outcome and experience.

10.9 Ward to board reporting

Ward to board reporting could be significantly strengthened to provide a high level of assurance. Currently the Trust board are receiving reassurance. It was unclear who authored the reports and the check and challenge the report received before being presented at executive level.

Recommendations

- 74. A specific quality and safety report should be presented as a minimum of quarterly alongside a Biannual perinatal specific workforce report. The MIAs can provide example templates of these to ensure more robust oversight of the quality and safety of services.
- 75. The current meeting structure within maternity could benefit from being reviewed alongside current TOR to ensure the right level of documents and escalation is provided with appropriate check and challenge to gain high level assurance and be aware of blind spots and red flags within the service.

10.10 Safety Champions

The visiting team noted several safety champion posters around the unit at LGI, unfortunately these were considerably out of date. Staff could not articulate how board level safety champions conduct staff engagement or the process they could use to escalate any concerns or feedback. Several staff that we spoke to did not know who the safety champions were.

The NED safety champion has not currently undertaken safety walkabouts on the LGI site and maternity experience is only discussed through CNO reports at the Trust board. The new MIS for year 7 has been published and provides recommendations around MNVP and Safety Champion collaboration. Alongside meeting with the perinatal leadership team. clinical leads or triumvirate.

Recommendations

- 76. To review the requirements of MIS and current reporting mechanisms to ensure ongoing compliance with safety action 9.
- 77. The safety champions and their roles should be defined and shared with all staff.
- 78. Safety champions to review how staff and service user engagement could be enhanced.

10.11 Escalation / operational pathways

A robust escalation process is critical to maintaining a safe maternity service. There is currently no midwifery manager on call and the clinical staff are reliant on using the Trust wide site team and escalation policy. This was raised by the CQC, and no definitive plan has been made as how to address this. Often escalation is when staffing is critical due to activity and acuity and to have no midwives to be able to call upon to support leaves the Trust carrying a significant safety risk.

There is no formal midwifery SOP or escalation guidance to support staff, operational flow coordinators are in post but work cross site with some remote working, the majority of large organisations have moved to having flow midwives' site specific who can have oversight of activity and acuity and staff rostered on duty and fill rate gaps

The team reviewed documents and discussed staffing oversight and escalation with the teams. Staffing levels were a consistent theme heard during the visit.

The service has the advantage that that midwifery staff are used to working on both sites and are flexible in their working areas. The service could replicate processes undertaken in other services whereby all midwives participate in an on-call rota to be called in in times of escalation to the hospital areas.

Recommendations

- 79. Develop a midwifery and obstetric escalation SOP to support staff and senior midwives when managing high activity / acuity and rota deficits.
- 80. Review and strengthen the roles of the flow midwives to always be site specific with an onsite presence. These roles are pivotal in ensuring minimising delays in clinical care and supporting cross site planned and unplanned activity.

11. Quality Improvement (QI)

11.1 Trust-wide approach and training programme

The Trust has an Improvement Strategy 2024–2028, which presents a clear, values-led framework aimed at embedding continuous Quality Improvement (QI) across the organisation through seven strategic objectives.

Staff have access to a QI training programme, the “Leeds Improvement Method”, based on the Lean methodology and the Virginia Mason principles, structured at basic, silver, and gold levels.

Each CSU has access to advanced QI expertise through the Kaiser Promotion Office (KPO) and have QI Crew leading internal improvement programmes.

Quality Improvement (QI) initiatives are increasingly aligned with the Cost Improvement Programme and a £1.9 million target is in place for the Women’s Services CSU, as part of the Waste Reduction Programme, with examples of progress including enhanced in-house smoking support.

11.2 Perinatal services

There is a QI Crew in place, established several years ago, which brings together staff with silver-level QI training. The QI Crew includes the Consultant Midwife, Digital Lead Midwife, Business Services Manager, Outpatient Matron, Workforce Lead, and Quality and Safety Lead. There are plans to expand the group by recruiting a representative from Gynaecology.

The QI Crew meets monthly to provide tools, guidance, and evaluation support for active improvement projects. Several specialist midwives have been actively involved in QI initiatives and medical staff also contribute to QI through audit presentations; however, QI training is reported as not mandatory for doctors.

There is clear evidence of Quality Improvement (QI) being integrated with Quality and Safety, particularly where projects have been initiated in response to clinical incidents—such as postpartum haemorrhage (PPH) and the OASI care bundle. QI is a standing agenda item in subspecialty governance meetings, with additional fortnightly meetings involving matrons to support alignment and oversight. The QI Crew works closely with the Quality and Safety team to translate incident themes into improvement actions. For example, in response to high OASI rates, they introduced a teaching trolley and engaged directly with staff, including medical teams, to raise awareness and improve practice. A separate project targeting PPH achieved a statistically significant reduction in rates within three months. Postpartum governance meetings are held monthly to monitor clinical outcomes and support ongoing learning.

Other ongoing areas of focus include the Civility in the Workplace QI project, which offers staff training—though this is not yet mandatory. Personalised Care is also being prioritised, with training embedded in both preceptorship programmes and specialist midwifery pathways. In addition, there is a continued commitment to service user involvement, with recognition of the need to improve diversity. Work is ongoing with the Maternity and Neonatal Voices Partnership (MNVP) lead to ensure a broader and more representative range of voices are included in improvement activities.

Areas of Good Practice

- The Trust incorporates equity and equality assessments into QI processes, ensuring that improvement efforts are inclusive and aligned with broader organisational priorities.
- The establishment of the QI Crew, supported by a dedicated KPO structure, has provided a clear framework for quality improvement. A standard operating procedure is reported as in place, and regular monthly forums offer ongoing project support.
- Staff are actively encouraged to submit QI project ideas via QR code or email. Suggestions are coordinated by an administrator and supported through the Improve Well platform, helping to streamline project initiation and tracking.
- Increased service user involvement in training sessions in the last year, with real case scenarios re-enacted by staff during study days, followed by reflective discussions on staff responses.

- Service users are also actively involved in PROMPT and Saving Babies' Lives training, ensuring that lived experience informs clinical education.
- ST3 doctors receive mandatory training on QI and audit and have weekly opportunities to present audits and case discussions during the Friday afternoon teaching sessions.

Challenges

- Despite the Trust's comprehensive improvement vision, there are significant gaps in communication, visibility, and engagement. None of the staff interviewed during the visit referenced or appeared familiar with the Improvement Strategy, highlighting a disconnect between strategic direction and frontline awareness.
- While multiple QI initiatives are underway these are not currently integrated as part of a Perinatal Improvement Plan.
- Staff engagement in improvement activities appears limited, with the approach perceived as more assurance-driven than improvement-focused and lacking meaningful bottom-up involvement.
- Quality improvement (QI) training has also been identified as a significant gap. Many staff in key roles—including specialist midwives, ward managers, and matrons—have not received any QI training.
- There is currently no formal mechanism to identify, track, or discuss QI training as part of appraisals or personal development reviews.
- Furthermore, there is no system in place to monitor training uptake across maternity and neonatal teams, either by leadership or education leads.
- The maternity dashboard currently relies on a RAG rating system, which limits the ability to analyse trends, understand variation, and track performance over time.
- Leadership behaviours were frequently raised as a concern. Staff reported a lack of collaboration, shared vision, visibility, and active engagement. Concerns were expressed about decisions being made without staff involvement, leaders changing direction in open forums—undermining others—and a general lack of accountability. This has contributed to a longstanding sense of dissatisfaction, with staff feeling excluded from decision-making and disempowered to lead improvements.
- Cultural issues were also evident. Staff described a defensive culture, lack of strategic clarity, and a disconnect between senior leaders and clinical teams. While various listening events have been held with senior leaders (including the Chief Nurse, Non-Executive Directors, and HR), practical outcomes from these have yet to be clearly communicated to matrons and team leaders.
- Several operational challenges were noted during the visit. Despite long-standing implementation, BSOTS is not effectively embedded. Staff reported persistent staffing shortages, lack of training for midwives and doctors and infrastructure issues such as broken intercom and CCTV systems, which have not been addressed and formally captured on the risk register, indicating a lack of system-level oversight and response.

- These leadership, cultural and operational challenges have directly impacted the quality improvement (QI) agenda, weakening staff motivation and confidence to engage in QI, contributing to scepticism about the value of improvement efforts. As a result, QI is often perceived as a top-down requirement rather than a meaningful, team-led approach to improving care.
- Walkabout in clinical areas highlighted lack of QI boards and QI huddles.
- Staff in different roles reported limited time and capacity for quality improvement due to staffing shortages, clinical demands, frequent redeployments and high levels of assurance work.
- There was frustration around completing action plans for the Perfect Ward initiative, especially where aspects were not seen as relevant to maternity services.

Recommendations

81. The Trust should consider strengthening strategic communication and visibility and clearly cascading the Improvement Strategy to all staff levels.
82. Align existing QI projects as part of a unified Perinatal Improvement Plan.
83. Encourage staff participation of QI training, with an emphasis on high-impact roles (e.g., specialist midwives, ward managers, matrons) and set up clear expectations of applying the learning on on-going initiatives.
84. Incorporate QI training into appraisals and personal development plans.
85. Develop process to monitor QI training uptake e.g. by education, HR, and clinical leadership.
86. Expand visibility and involvement of senior leaders across both sites.
87. Identify a small number of high-priority- or complex initiatives- requiring targeted QI focus.
88. Transition the maternity dashboard from a RAG rating system to Statistical Process Control (SPC) charts to enable more robust analysis of trends, variation, and performance over time and provide necessary training to staff
89. Undertake a Structured QI project to improve leadership behaviours, culture and staff engagement
90. Address the effective implementation of BSOTS as a QI project where staff and service users contribute to identify robust and sustainable solutions, including refreshed training for all clinical staff (medical and midwifery).
91. Set clear expectations that key staff (e.g. ward managers, specialist midwives, matrons) lead and participate in QI, with responsibilities reflected in job descriptions, appraisals, and development plans.

92. Review Perfect Ward expectations for maternity, ensure audit content is relevant and meaningful.
93. Consider implementing and maintaining QI huddles and QI boards accessible to staff to application of QI methodology and staff engagement to enhance staff engagement, support continuous improvement efforts, and improve the application of QI methodology.

12. Service user / staff experience

12.1 Maternity and Neonatal Voice Partnership

The visiting team met with the MNVP lead. She has worked incredibly hard to engage with the communities that use the services in Leeds and described a good working relationship with the health equity consultant midwife. The MNVP engages with diverse families through things like their diverse women's group. The MNVP shared some details of engagement events and focus groups as well as walking the patch and 15 steps events on site at both LGI and St James'. The MNVP lead attends the Women's CSU quality assurance meeting and has recently been invited to attend safety champions (since January 2025), she does not attend PMRT, patient safety meetings, audit meetings or guideline committees as suggested in MIS and the MNVP guidance. The MNVP does not have an established relationship with the NED safety champion and hopes this will develop now they are attending the safety champions meetings. The MNVP raised that they are unsure of the "so what" following their engagement. They share intelligence with the Trust but have not seen much action or response. They are unaware of any action plans that may have been created following their engagement with the communities. The MNVP lacks strategic influence at Trust level, they are not included in decision making and are not able to provide critical friendship or advice to senior leaders within the Trust. The MNVP felt able to escalate to the deputy HoM if they had immediate concerns about a situation or family and felt this would be taken seriously. We would recommend working with the ICB to explore how to build on the good engagement foundation the MNVP currently has and expand their capacity and knowledge base to be able to provide strategic leadership embedded alongside the leadership at provider level and scrutiny through a service user voice lens within quality oversight and patient safety as per MNVP guidance, examples of service specifications, job descriptions and workplans can be shared.

12.2 Service user feedback

The main themes in the service user feedback from the MNVP include postnatal care, especially on the ward and choice/consent/communication. The MNVP shared some

distressing feedback with us from a service user who had reported an interaction with a doctor during her perinium repair which illustrated lack of valid consent and continuing a procedure after being asked repeatedly to stop, causing great distress. The MNVP also shared that some service users reported identifying tension between midwives and doctors, saying their midwife was acting as an advocate for them and having to argue against the doctor in the room during labour.

The visiting team spoke to current service users on the wards, at LGI and women on the Postnatal ward, Transitional care and Antenatal ward. They reported similar themes around lack of compassionate communication throughout their journey. They fed back that there were some amazing individual members of staff that treated them well, but they felt the staff were overwhelmed and understaffed.

Families on the postnatal ward talked about delays in discharge without clear communication. They were sympathetic to how busy the ward was and how there may be a good reason for the delay, but nobody had communicated with them.

Infant feeding support was something else that was raised. A family who had planned to breastfeed and had a long and difficult birth had been given formula on the ward because there was nobody available to support once baby would not latch. This family was upset and disappointed that they had been made to give formula.

At the St James' site three service users reported not being listened to, particularly during the antenatal period. Two service users had multiple visits to the Maternity Assessment Centre due to concerns such as reduced fetal movement and pain, but both felt dismissed. One user, after presenting three times with reduced fetal movement, was not offered a scan, later undergoing an emergency caesarean birth due to fetal distress. Reports of rough and frequent vaginal examinations were made, without appropriate consent, with one service user expressing that these left her feeling sore and distressed. One service user reported excellent postnatal care, highlighting that both she and her partner felt comfortable and had consistent and appropriate access to maternity staff.

12.3 Navigation and communication

There was limited translated communication, with some materials available in different languages but an overall lack of comprehensive multilingual support what information was provided was out of date. Signage across the service was scarce and unclear making it difficult for service users to find their way around, particularly across different units. Out of date posters space constraints compromised privacy and dignity particularly in assessment rooms and shared ward areas

Antenatal clinic area not welcoming and still had Perspex screens that were put up during covid which acted as a potential barrier between the service user and clinical staff. There were rules around visiting displayed with no options of how to discuss this with staff if needed.

Lotus suite could be considerably improved to provide a more welcoming area.

There is a disconnect between maternity and neonatal services the visiting team hear staff describe there is one maternity service and one neonatal service

The child health information record – red book is not given at birth which can cause issues for out of area women.

Language line, although available is not used as widely as it could be, which was evidenced for some postnatal debriefs.

Co production was highlighted as a current challenge and engagement in meeting alongside full cop production of services and pathways.

Recommendations

94. Working with MNVP on specific co-produced areas of improvement work especially the environment.
95. Ensuring the MNVP is a core member of all meetings and is included in key midwifery recruitment.
96. The Trust would benefit from reviewing and engaging the MNVP in the safety champions meetings and meet with the Non-Executive Director (NED) for Maternity services on a regular basis

13. Culture and Engagement

There were some examples of poor communication, changes to ELCS pathway at SJH, this was not communicated clearly to ward staff. It was not clear who had responsibility for women on the wards awaiting LSCS. The introduction of agency midwives on the postnatal ward, the staff felt that this was the right thing, but it was not well communicated with them

Staff report that they had recently had the opportunity to meet with senior leaders and executives. They reported that they felt that they have not had the opportunity to speak at the time of the visit they felt they had not been heard as they had not had any feedback or seen any examples of being listened to

Recently there was communication regarding all specialist and non-specialist nonclinical midwives undertaking 50% clinical shifts. This was communicated by e mail and later retracted. Although the staff group were understanding of the need for this ask, there were upset that the executive team had not discussed their decision with them directly.

Recommendations

97. The Trust would benefit from some focused cultural work and support from ward to board to ensure that leaders and staff feel psychologically safe to raise concerns that will be listened to and supported.

14. Staff experience

The midwives and support staff describe a need for positive change within the team dynamics. There was feedback and acknowledgement from the senior midwifery teams that they generally supported one another in terms of escalation, however their main concerns had been safe staffing, culture and burnout.

Staff described a lack of leadership presence, and this could be contributed to the lean leadership structure, and this contributed to feelings of isolation amongst the front-line staff specifically on the LGI site.

All staff that the visiting team spoke to articulated their frustrations at escalating safety concerns with little or no feedback or resolutions. Staff frequently reported that concerns and escalations were ignored or rejected, leaving them feeling vulnerable and unsupported.

Despite these challenges, frontline staff remained highly passionate, solution focused about patient care, with a real desire to improve services but organisational barriers hindered their ability to provide optimal support. Sadly, we heard from several staff that did not feel valued or listened to and were leaving the organisation. Staff expressed frustration about being unable to provide the standard of care they aspired to due to ongoing systemic issues.

Staff described high workload and fatigue the cumulative effect of covering multiple roles, with the focus on managing immediate crises and escalations, rather than on proactive quality improvement has contributed to a culture where innovative ideas and improvements are often stalled by bureaucratic delays and lack of senior and executive support.

Constant travelling between sites and being involved in persistent escalation issues has led to significant stress amongst the matrons and frontline staff the impact on morale is having an impact on improvements and the provision of assurance.

There was a visible and tangible leadership hierarchy, and staff reported not feeling psychologically safe to raise concerns and described escalation fatigue.

The team met with the freedom to speak up guardian (FTSU) who has minimal hours to cover the whole organisation and verbalised the nature of concerns that were raised to them from maternity services, but overall had a low rate of staff reporting concerns from maternity.

Recommendations

98. The Trust should review the hierarchical structure to ensure a more even power base
99. Consideration of a communication strategy with input from staff to ensure this captures all methods of effective communication of key messages
100. The Trust would benefit from site specific midwifery leadership roles as previously described
101. Strengthening the relationship between clinical teams, safety champions, and senior management is essential. This might include more leadership sessions on the shop floors to provide direct support and a clearer chain of feedback and executive accountability.

Training evaluation surveys for resident doctors

The GMC NET survey for 2024 demonstrated that both LGI and St James' were within the interquartile range for all measures assessed (with improvement noted particularly for St James where they had been below expected ranges for some areas in 2023). The RCOG TEF survey (2024) did however demonstrate that LTHT were below the mean for the Deanery across several quality measures including workplace behaviours, clinical govern

15. Equality, Diversity and Inclusion

All Trust executive leads have EDI responsibilities within their portfolios, the National Maternity Lead for equality at NHSE will be undertaking some targeted oversight and support with the organisation and named MIA and provide the Trust with areas of good practice and areas of improvement.

The Trust have an aspiration to increase workforce diversity not only in maternity services but across the Trust which can bring a range of significant benefit, particularly in improving care quality, addressing health inequalities, and fostering a more inclusive and culturally competent health care environment reflective of the local population.

16. Conclusion

Following receipt of the diagnostic report a Regional rapid quality review meeting will be convened for all stakeholders to review and agree the level of support for the Trust.

17. Next steps

This report will be shared with

1. The Trust executive and perinatal clinical leadership team
2. The Regional Chief Midwife and Regional Obstetrician
3. The Regional Chief Nurse and Medical Director
4. This will be reported to the Regional JSOG

18. Exit criteria

Action / Recommendation	Evidence required	Trust lead	Agreed completion date	Progress