University Hospitals of Leicester NHS Trust

St Mary's Birth Centre

Inspection report

Leicestershire County and Rutland PCT
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Ratings

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

Our findings

Overall summary of services at St Mary's Birth Centre

Good ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Saint Mary's Birth Centre.

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

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

We carried out an announced focused inspection of the maternity service, following 48 hours' notice. We only looked at the safe and well-led key questions.

We also inspected maternity at Leicester General Hospital and Leicester Royal Infirmary, run by University Hospitals of Leicester NHS Trust. Our reports are here.

Leicester General Hospital – https://www.cqc.org.uk/location/RWEAK

Leicester Royal Infirmary - https://www.cqc.org.uk/location/RWEAA

How we carried out the inspection

Maternity services at St Mary's Birth Centre include antenatal, intrapartum (care during labour and birth), and postnatal care. Services were provided in a dedicated centre on the premises of the Melton hospital site in Melton Mowbray. The trust rented the building from a private landlord. The midwifery-led unit provided intrapartum care for women and birthing people who met the criteria and were assessed to have low risk pregnancies.

The birth centre (BC) had 2 birthing rooms which both included a pool for labour/birth, and ensuite facilities. The BC also had an 8- bedded postnatal ward where staff provided extended postnatal care to women and birthing people, regardless of whether their babies had been born there. This was of particular benefit to women and birthing people with complex needs or those who needed additional support with breastfeeding.

One hundred and thirty-seven women and birthing people had been cared for in labour in the calendar year 2022.There were 95 births, and 42 were transferred to the main unit(s). This equated to a transfer rate of 30.7%.

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

Maternity

Good

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

- The leadership team were new and embedding and developing a strategy with key stakeholders to implement their vision.
- The leadership team were working with staff and an external agency to improve the culture across all 3 locations, although SMBC staff described happy, healthy relationships.
- Staff were focused on the needs of women and birthing people receiving care, and staff were clear about their roles and accountabilities.

However:

- Leaders did not always operate effective governance processes throughout the service.
- There was limited evidence and visibility around the birth centre at board.
- Equipment was not always checked in line with guidance to ensure it was safe and ready to use.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Midwifery staff and maternity care assistants received and kept up-to-date with their mandatory training. Training compliance was over 90% for all training modules, although the majority were 100%. This was against a trust target of 95%. There was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people, and babies, and improved relationships with staff from the main units.

The mandatory training was comprehensive and met the needs of women, birthing people and staff. The service made sure staff received Practical Obstetric Multi-Professional Training (PROMPT) and staff practised ad hoc skills and drills specific to an out-of-hospital environment. However, they did not maintain a record of this, and staff did not always receive regular pool evacuation training, although they were able to describe the process, and told us they practised this during ad hoc skills and drills.

Aromatherapy was also offered by midwives who had completed training.

Managers monitored mandatory training and alerted staff when they needed to update Staff said they received email alerts, so they knew when to renew their training. Managers were informed if any staff did not attend or required additional training. This helped managers to maintain oversight of attendance and provide additional support when needed. Staff had time off to complete training but were offered time back or payment, if they attended training in their own time.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that 100% of staff had completed both Level 3 safeguarding adults and safeguarding children training, as set out in the trust's policy and in the intercollegiate guidelines.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The birth centre (BC) had access to the safeguarding team for support with any queries or concerns.

Staff followed safe procedures for children visiting the postnatal ward, although visiting information on their website was not correct, as it stated partners could stay overnight. This had changed during the COVID-19 pandemic, to reflect the same visiting times as the main units. The manager told us BC staff had practised what would happen if a baby was abducted within the 12 months before inspection. However, they had not maintained a record of this.

Cleanliness, infection control and hygiene

The service controlled infection risk well. They kept equipment and the premises visibly clean but did have a process for changing curtains and blinds.

The birth centre (BC) was visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after contact with women and birthing people and it was clear equipment was clean and ready for use. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, due to the estate, some pipework in the bathrooms were rusty which meant they could not be effectively cleaned.

Staff followed infection control principles including the use of personal protective equipment.

Not all curtains were disposable and there was no process to ensure a regular cleaning regime. We also noted one disposable curtain was visibly clean, but the change date had expired. We highlighted this to the community matron who told us they would attend to this.

Environment and equipment

The design, maintenance and use of facilities, premises kept women and birthing people safe, however, equipment was not always checked to ensure it was safe and ready for use.

Maternity

The maternity unit was fully secure. The reception point was located immediately beyond the entrance and clearly visible from the entrance. The main doors to reception opened automatically to the reception point and there was a bell to ring on arrival. All other areas including the staff meeting room were locked and only accessible through staff swipe cards. The environment was secure.

There were 2 labour/birthing rooms. Both rooms included a birthing pool, birthing balls, stools and floor mats. They included air conditioning, dimmable lighting, electric candles and music to promote a calm and tranquil feel.

The pool for one room was in an adjoining room, but we noted the doorway was too narrow to use a hoist or nets to support an evacuation in an emergency. We highlighted this immediately to the Director of Midwifery (DoM), who was on site at the time. They contacted the landlord and requested an immediate risk assessment and suspended the use of the room. This was swiftly communicated to all staff, and laminated posters were put on the door to the room, to confirm it was out of use. The DoM was receptive and responsive to our concerns, but it was difficult to understand how staff had practised an emergency evacuation without noticing this.

The service had enough suitable equipment to help them safely care for women, birthing people and babies. For example, there were pool evacuation nets in both labour/birth rooms, a shared neonatal resuscitaire for the 2 birthing rooms, and observation monitoring equipment.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

We sampled electrical equipment and saw electrical safety testing was not always in-date. For example, the safety check for an electrical thermometer had expired in May 2022, the safety check for baby scales had expired in December 2022 and for the clinical fridge in February 2023. We highlighted this to staff who told us they would attend to this.

Staff disposed of clinical waste safely most of the time. Sharps boxes were signed and dated. However, we noted sharps boxes were not always closed after use which was a safety risk in an environment where children visited.

Staff carried out daily safety checks. For example, records showed that resuscitation and emergency equipment was checked twice daily (on every day and night shift). There was a standard operating procedure that provided guidance regarding the cleaning of the birthing pools and legionella checks. We saw that all hot and cold taps, including pool taps were run for 5 minutes twice weekly.

Assessing and responding to risk

Staff mostly completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

We reviewed 2 maternity care records. The lead professional was confirmed, and risk factors were highlighted. Both women had routine blood tests and carbon monoxide screening recorded. They were asked about their mental health and domestic abuse, and their fetal movements were recorded at their birth centre (BC) contacts. However, 1 of the 2 women had not had their risk assessed for venous thromboembolism on arrival in labour, and during post-natal care, Staff had not plotted the baby’s growth for 1 woman and neither woman were given advice about the importance of vitamin D supplementation during pregnancy and breastfeeding.

Staff encouraged community midwives to refer women and birthing people to the BC, although they would accept self-referrals too. Staff completed risk assessments for women and birthing people at 36 weeks, to determine their suitability to birth there. However, we did not see a fresh risk assessment on admission in labour. Maternity services audited compliance to this requirement. We saw that 100% of women and birthing people had a risk assessment at every contact in December 2022, and 94% in January 2023. However, the results were not site specific and we were unsure if the BC was included.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 2 MEOWS records and found staff correctly completed them. However, we requested audits of MEOWS for the 3 months prior to our visit and the returned results did not reflect specific results for the BC.

The service had 24-hour access to mental health liaison and a specialist mental health team for support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns and we saw that they routinely ask about mental health during pregnancy.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. We attended the handover between night and day staff and key information was shared.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure community midwives and third-party organisations were informed of the discharge.

Leaders monitored transfer times from the BC to the main unit(s). Transfer times could take up to an hour in an emergency. There was an agreement with the local ambulance service to try and ensure such requests were given the right level of priority. This was discussed with women and birthing people during their appointment at 36 weeks. Staff used a specific checklist which included potential transfers and transfer times. Information was also displayed on the trust website, although this reflected transfer times for 2020, not 2022.

The service did not monitor that the conversations about potential transfer times took place. The service could not be assured women and birthing people had received the information in order to make an informed decision about their place of birth. However, the community matron told us they had never received a complaint or negative feedback regarding the transfer times.

The consultant midwife held a birth choices clinic to provide additional information and shared decision making for women and birthing people who require additional guidance where they do not fall within the low-risk birth guidance. The consultant midwife worked in partnership and supported the BC where women and birthing people wanted to deliver there, and a risk assessment was required.

Midwifery Staffing

The birth centre had enough suitable staff to keep women, birthing people and babies safe. Birth centre staff were not part of the escalation process. Staff had recent appraisals.

The birth centre (BC) had sufficient staffing levels on the day of our visit. Community midwives were part of the escalation process when staffing levels were unsafe, or there was high acuity at the main unit(s). However, BC staff were

not part of the escalation process, even if the main units had unsafe staffing levels and the BC was vacant. This was due to concern that if the BC was closed and this had been communicated to women and birthing people, they might still present in labour. Community phonelines were diverted to the BC if community staff were deployed to the main unit(s) during times of high acuity.

We were told it would be very unusual for the BC to be vacant and that at times of high acuity and short staffing at the main units, managers collaborated to determine which mothers and babies were suitable to transfer to the 8-bedded postnatal ward. They also organised for well babies who were suitable for early discharge to attend the BC for the newborn physical examinations. Midwives handed over care to hospital staff following all transfers, although if hospital staff were very busy, some level of care was offered on arrival.

Staffing issues and acuity fed into the safety meetings with the main units, twice daily. The team leader or nominated BC midwife joined virtually. This ensured staff at the main hospitals had an overview of the BC, and they could collaborate to support each other. Issues were escalated in between meetings to the labour ward coordinator, as and when needed. During the factual accuracy process the service provided evidence which showed planned and actual staffing numbers matched.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A maternity 'red flag' event is a warning sign that something may be wrong with midwifery staffing. However, we could not determine if there were any red flags related to the BC as they were amalgamated for all 3 locations.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Ninety-five percent of staff had a recent appraisal and they told us they were meaningful.

A practice development team supported midwives and there was a recently appointed recruitment, retention and pastoral midwife specialist to support community and BC staff. Managers made sure staff received any specialist training for their role. For example, BC midwives had all completed the newborn and infant physical examination course.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive. We reviewed 2 paper records and found records were clear and mostly complete. All entries in the handheld notes were dated, timed and signed.

Records were a mixture of electronic and paper. The birth centre also accepted out-of-area women, birthing people and babies for postnatal care and support whose electronic records were stored on a different system that staff could not access. Gaps between different digital systems and paper documentation impacted the ability to have complete oversight of women and birthing people and could create risk.

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

Medicines

Maternity

The service used systems and processes to safely store medicines.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

We did not review any prescription charts during our visit.

Incidents

Managers investigated incidents and shared lessons learned with the whole team.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. Staff did not report staffing shortages as an incident. They recorded any additional hours worked so that they could be renumerated or received the time back. However, this meant there was no oversight or monitoring of this.

There had been no serious incident investigations related to the BC since 2020. However, learning from serious incidents, incidents and complaints from the main units were shared by the community matron and team leader. Information was cascaded by email, learning bulletins and a safety newsletter.

Staff told us there was a process to ensure staff were supported in the event of a serious incident or difficult situation such as an emergency transfer. They told us they would be debriefed and offered a variety of support which could include a trauma risk management (TRiM) referral, support from a manager professional midwifery advocate or colleague. TRiM practitioners are non-medical personnel who have undergone specific training allowing them to understand the effects that traumatic events can have upon people.

Is the service well-led?

Requires Improvement

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

Leadership

The leadership team had been restructured and many posts were new and embedding. They understood the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The chief nurse had taken up post in May 2022 and quickly reviewed the midwifery structure. They had restructured to ensure there was leadership capacity to support all 3 locations. This included a newly created director of midwifery (DoM), an additional head of midwifery (HoM), site specific matron and newly created specialist positions.

Maternity

The clinical director (CD) was a consultant neonatologist at Leicester Royal Infirmary and a second newly created deputy clinical director was due to commence on 1 March 2023. The CD and deputy CD covered all 3 locations, but Heads of service were site specific.

A community matron had oversight of the birth centre along with a full-time team leader. The increased leadership team was created to improve oversight and ensure a culture of assurance rather than reassurance.

The DoM commenced on 1 January 2023 and at the time of our inspection were supported by 1 HoM. An additional HoM had been created and commenced on 3 April 2023. The leadership team was also supported by 1 consultant midwife, 2 site specific matrons, specialist midwives, band 7 midwives, and the governance team. The chief nurse had commissioned an external review of all speciality posts. The review commenced 3 weeks prior to our inspection and was due to be completed end of March. They wanted to ensure they had the right staff to develop the service.

At the time of our inspection there was a live advert for an additional matron to act as the named midwife for safeguarding. There was also a live advert for site specific maternity service co-ordinators to provide 24-hour cover at both main units. This was to provide site-based leadership and helicopter oversight of the service.

Many of the additional senior posts were new appointments and not fully embedded. However, the DoM had settled quickly, understood the issues, and was prioritising the main risks. The senior leadership team and clinical management group had protected the first week of April 2023 to focus on getting to know each other and working as a team. An external company had been commissioned to facilitate the time together. They were committed to working together to focus on driving improvement.

Maternity services had 6 safety champions. This included a non-executive director (NED) and chief nurse as board champions, supported by a clinical midwife, an obstetrician, a neonatal nurse and a consultant neonatologist. They engaged with staff and service users on walkabouts, to obtain views on safety. Frontline safety champions linked with the trust board to advocate for safety in their clinical areas. The NED ran a monthly online drop-in for maternity and neonatal staff to raise concerns about safety, and ideas for improvement. It was online following staff feedback, and this ensured it was accessible to community and birth centre (BC) staff too.

The safety champions updated the trust board monthly on issues that required board-level action. The minutes of trust board meetings reflected challenge on maternity and neonatal services from the NED for maternity services.

The chief nurse/midwife reported directly to the board since May 2022 and presented midwifery papers/reports and quarterly updates on progress and compliance with recommendations from the Ockenden Report (March 2022). Monthly maternity performance indicators were reviewed by the board. The DoM presented midwifery papers/reports and quarterly updates on progress and compliance to Ockenden recommendations. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies.

The community matron was visible and approachable in the service for women, birthing people and staff. They spent 1 day every month at the BC and were available for staff off site. The midwives were supported by a full-time team leader who was based at the BC and they were also supported by BC maternity care assistants. Leaders were well respected by staff who described them as approachable, and supportive.

Staff spoke highly of the new DoM and the additional appointments to the leadership team. The DoM was working from the BC on the day of our visit. This had been planned in advance of our announcement. They started at 7am to be able to spend time with the night staff and planned to spend regular time at the BC to get to know staff, understand any issues and implement improvements.

Leaders encouraged staff to take part in leadership and development programmes to help all staff develop their skills and take on more senior roles. The community matron was completing a nationally recognised leadership programme. Applications were encouraged from midwives who were band 6 and above, and we were told they were supported to apply for other leadership courses.

Vision and Strategy

The service had a vision for what it wanted to achieve and were developing a strategy to turn it into action.

The service had a vision for what it wanted to achieve and their strategy to turn it into action was in draft. The strategy was being developed with relevant stakeholders and in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

As part of the Leicester, Leicestershire, and Rutland (LLR) maternity and neonates' system, work was in progress to refresh and develop a strategy fit for the future. The leadership team wanted the strategy to be informed by national plans and staff and people who use the service.

Maternity services across University Hospitals of Leicester (UHL) wanted their new five-year strategy to be co-created, and for it to become part of a movement that everyone had played a part in. They wanted the insight from the externally commissioned engagement project and conversations with staff and external providers to inform their new draft strategic framework for UHL. This was expected to be finalised in Spring 2023.

Culture

Staff had not always felt respected, supported, and valued, but the leadership team was committed to developing an open culture where women, birthing people, their families and staff could raise concerns without fear. Staff were focused on the needs of women and birthing people receiving care. The service provided opportunities for career development.

Staff received mandatory training in conflict resolution and bullying and harassment annually. Compliance was 95.4% and 98.1% respectively. All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff were passionate about working at the birth centre (BC), supporting choice and normality, and described the team 'as like family.'

Managers told us culture had recently been added to the maternity risk register as historically staff had not always felt respected, valued and included**.** The leadership team were aware of this through their own intelligence, and this was considered a factor in staff retention, although we could not see that culture was included in the risk register.

However, staff at the BC described healthy, supportive relationships which was also reflected in feedback from students. Managers had supported staff outside of the BC to understand the diversity of role of the BC team and how they could

support the main units. Staff had recently presented an example of a 'Day in the Life of the BC Team.' They described an appreciation and understanding of different roles between hospital staff and worked in partnership. For example, they accepted postnatal transfers to the BC for ongoing care and support, booked babies for the examination of the newborn checks and women and birthing people could transfer for continued breastfeeding support.

They described improved relationships. For example, colleagues outside of the BC had provided cover to enable staff to have some grieving time and attend a service when a BC colleague had sadly passed.

A matron had been recruited in November 2022 to focus solely on recruitment, retention and staff wellbeing. They were leading a team of 3 recruitment and retention midwives which included 1 member specifically for community services and the BC. The lead was engaging closely with staff to understand why there was an issue with staff retention and reviewing local intelligence. This included feedback from exit interviews and an action plan was developed in response. Some quick wins had been positively received. For example, flexible working options, and an additional incentive payment for staff who worked a bank shift of 6 hours and above.

The chief nurse was committed to improving the culture. They had commissioned a comprehensive listening exercise across all 3 locations (known as the Empowering Voices programme) This was in response to their own intelligence and concerns raised through the Freedom to Speak up Guardian. EV was in progress at the time of our visit, and included staff focus groups and 1-1's for all staff.

The purpose of this project was to better understand the culture and focus on the things that mattered to staff. Staff were expected to take ownership and suggest and develop solutions. The project focused on engaging with all staff to make the solutions everybody's responsibility. Action plans were developed by staff not managers, to ensure everyone was committed to the improvement and transformation of maternity services.

Staff reported positive feedback about the opportunity to share experiences, concerns, and ideas for improvement. They saw the project as meaningful and spoke highly of the newly appointed senior leadership team who were described as visible, available, engaging, and dynamic. They described an improving culture where they felt able to speak to leaders about difficult issues.

Other work included review of the preceptorship programme, focus on recruitment, retention and pastoral support, Active Bystander sessions, engagement in the Nursing and Midwifery Council pilot for Professional Behaviours Patient Safety, and increasing attendance at a variety of leadership programmes such as Leading an Empowered Organisation (LEO)

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups, in their local population. Staff received mandatory training in equality and diversity annually to help them identify and reduce health inequalities. Compliance was 97% as of February 2023. The service had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement. They were also planning a conference for June 2023 to focus on health inequalities.

There was a task and finish group to reduce inequalities across their pregnant population. Maternity services had been identified as a pilot site to address the issues highlighted in the Birthrights report (2022), following the year-long inquiry into racial injustice in maternity services.

Maternity

Maternity services were also involved in a local system-wide approach to decide how to identify interventions and actions to improve equity and equality in maternity and neonatal care. A listening exercise was completed in June 2022 to ensure the experiences of local people who accessed maternity services in the past were heard. This involved using multiple methods to engage with the local community and gather their feedback. This included a survey and 9 engagement events at a variety of locations, and with partner organisations.

A key theme throughout the feedback was the importance of understanding and including cultural differences in all aspects of care, and in the information being provided to parents. The programme made recommendations for initial next steps. This included community asset mapping, developing a peer support training programme, developing community hubs and ensuring all information was available online and in one place, to avoid duplication and share best practice.

The community matron investigated complaints and shared feedback and themes form complaints related to the main units, with staff. Learning was used to improve the service. Complaints were a fixed agenda item for every team meeting. We reviewed complaints for all 3 locations for 3 months prior to our inspection, and noted none of them were related the BC.

Governance

Staff at all levels were clear about their roles and accountabilities. However, leaders did not always operate effective governance processes, throughout the service.

Leaders wanted to improve governance processes, throughout the service and with partner organisations. The recently appointed director of midwifery (DoM) had reviewed the governance process as the senior leadership team had agreed it needed to be more streamlined and avoid unnecessary duplication. The neonatal and maternity service had separated its own governance structure. This ensured they still fed into the women's and children's board but separately, to avoid duplication.

The community matron attended monthly governance meetings, which included an update on recruitment and training compliance, review of risks, incidents, guideline updates and review of the maternity dashboard. However, a separate governance report was not produced for the BC. We saw limited evidence that the BC was discussed in local quality reports, which meant it was difficult to see how the board could maintain oversight.

Trust Board members and the public were informed in January 2023 that there would be a declaration of non-compliance to NHS Resolution, with only 2 of the 10 safety actions met. Actions for all standards with partial compliance were in progress.

Leaders did not have an effective process to monitor policies and review dates and the ownership, oversight and management of guidelines and procedures was unclear. Updated guidelines were disseminated by the team leader or community matron. Staff used QR codes to access guidelines. QR codes were stored in a laminated folder and made access quick and easy. Trust policy was to only refer to online guidelines. However, we saw staff referring to paper copies which meant they might not be the latest and most up-to-date version. For example, the proforma for use in the event of a post-partum haemorrhage was last updated September 2011 and due for renewal in September 2014.

Maternity

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Some policies were unclear and not comprehensive. For example, the waterbirth guideline did not include a clear process to follow if a woman or birthing person needed to be evacuated from the pool in an emergency.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. The BC completed an annual audit of their births. This included the positions women and birthing people birthed in, the transfer rate, reasons for transfers and time spent waiting for an ambulance. Staff had cared for 137 women and birthing people in labour in 2022 and 30.7% had been transferred.

However, although staff monitored transfer rates, and reasons for transfer, they did not audit outcomes. They audited birth positions but did not audit any potential impact. For example, perineal tears or blood loss. They also did not audit key information such as length of labour and birth weight. In addition, although some information was captured, a review of meeting minutes did not provide any indication as to how this information was used.

Transfer times from the BC were not collected in their entirety, and it was unclear how and when this information was interrogated or used to monitor impact on outcomes. Neither was it clear how this information was used to monitor the service provided to the trust by the local ambulance service.

There was a lack of monitoring and oversight of infection control and equipment and data specific to the BC was not included in the maternity clinical performance dashboard.

Staff at all levels were clear about their roles and accountabilities and were positive about the recent senior appointments. Staff understood their role within the wider team and took responsibility for their actions. In the most recent NHS survey for 2021 (published in February 2022), 89.6% of maternity staff said they always knew what their work responsibilities were and 71.3% said they were able to make suggestions for improvement. However, these results were amalgamated across all 3 locations.

Learning was disseminated by learning bulletins which included a brief synopsis of an incident, what was learnt, what the recommendations were, and what individuals should do to minimise the risk of recurrence. Quality Improvements, good news stories, and learning was also shared from reviews through newsletters and infographics, governance boards in ward areas and closed Facebook groups for staff.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and actions to reduce their impact.

The birth centre (BC) did not have a local risk register. The risks relating to closure of the free-standing birth centre due to staffing pressures or maintenance issues was not identified and mitigated as a risk.

The lack of end-to-end digital solution risk was being managed at trust level and included input form the community matron to ensure the needs and views of community and birth centre staff were represented and included.

Information Management

The service did not always collect reliable data and analyse it.

The birth centre (BC) did not always collect reliable data and analyse it. For example, birth outcomes and postnatal care provided to out-of-area women and birthing people were not collected in their entirety or scrutinised. Equally, data was not always separated for the BC which meant managers could not have complete oversight, identify issues and monitor improvements specific to the BC.

Information systems were not integrated. Staff had to write in handheld notes and then duplicate in electronic notes, which created opportunities for error. Gaps between the digital and paper documentation impacted the ability to have complete oversight of women and birthing people. We raised this with the senior leadership team and safety champions who shared concerns about potential duplication errors and a time-consuming system.

There was a large-scale digital transformation planned, to implement a new system. The trust was going through a procurement process and there was a digital lead to help ensure the implementation. This was expected to commence May 2023. The digital team had implemented some recent mitigations until the digital transformation was complete. For example, a facility to enable staff to book scans electronically and community staff had been issued with laptops, FiPads and handheld devices which linked between maternity systems and allowed access to necessary data.

Staff were provided with mandatory training on cyber security and general data protection regulation. Compliance varied between different staff groups, but most staff had completed the training. For example, compliance for birth centre staff was 90.4%.

Engagement

The new leadership team were actively and openly engaged with staff, equality groups, and local organisations to plan and manage services. They were committed to collaborating with partner organisations to help improve services for women and birthing people.

Leaders were committed to re-establish the local Maternity Voices Partnership (MVP), to contribute to decisions about care in maternity services. The MVP was established in Leicester in 2018 and been promoted on websites. Individual initiatives and programmes had been influenced by co-production with the MVP. For example, the option of displaying a ‘teardrop sticker’ for staff to identify someone who had experienced a pregnancy or baby loss.

However, the MVP had dissolved during the COVID-19 pandemic due to restrictions and pressures created by the pandemic. Maternity services had continued to engage with community groups such as Leicester Mamas (LM) during this time. LM was a well-established group who supported women and families across Leicester, around breastfeeding. They were about to re-launch the MVP with support from maternity services, and a Chair for the MVP had also been appointed in February 2023.

LM had well established links and relationships with maternity services and an imminent meeting was planned with the director of midwifery (DoM). The leadership team wanted to re-establish relationships and look at the required improvements identified in a review of the MVP completed in early 2022.

There was a specialist midwife for public health and inclusion for all 3 locations, and the service collected data on ethnicity. However, maternity services were not using the data to plan and target services to families most in need and tackle inequality.

Maternity

The service held an internal safety conference in February 2023 that was open to all staff. Speakers provided updates on many topics including translation services, Ockenden reports, learning from incidents and complaints, the digital transformation project and the student's voice. Their local investigator at the Healthcare Safety Information Branch and how to achieve a culture of candour.

The leadership team were largely new and embedding at the time of our visit. However, they showed a strong commitment and focus to collaborating with staff, families and partner organisations to drive improvements in their maternity service.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The birth centre (BC) had achieved baby friendly accreditation in 2019.

Leaders encouraged innovation. A consultant obstetrician had led on the development of an app specifically to support South Asian women and birthing people. The app was intended to address educational, cultural, and social barriers in pregnancy and the post-natal period. It aimed to provide culturally sensitive and linguistically appropriate information in multiple South Asian languages.

Women who had existing medical conditions were seen in multi-disciplinary clinics. The women had access to preconception advice, and support during pregnancy from specialists who worked in partnership with obstetric staff. For example, there were specialist clinics for women including renal, hypertensive, heart disease, epilepsy, diabetes, haematology, complex anaesthetic, history of pre-term labour and multiple births.

The Perinatal Mental Health Team (PMHT) clinic included a consultant obstetrician, a specialist midwife and a specialist mental health nurse from the Perinatal Mental Health Team (PMHT). The specialist midwife sat on the mental health board for the trust to ensure they raised the profile for midwifery and advocated for women and birthing people.

The PMHT team ran a weekly clinic and worked closely with the Maternal Mental Health Service. They had access to a broad range of treatments for mental health conditions in pregnancy, and if needed the team would offer appointment(s) at the women/birthing person's home.

The bereavement team for maternity services included obstetric staff and specialist midwives was available 7 days a week. The team ran a weekly clinic and provided continuity of care to women and birthing people who had experienced a previous baby loss. They also provided follow up support to women and birthing people following a baby loss, and offered the support at hospital, a community hub, or in the family home. The team were in the process of setting a support group for parents at the time of our visit.

The Trust created an event in February 2023 with talks that addressed some of the most relevant issues within maternity services today. For example, health inequalities. The event also included celebrations of all the good work that maternity staff had achieved and were working towards, to make their maternity service as safe as possible.

Maternity

Outstanding practice

We found the following outstanding practice:

- The local App which had been designed to address educational, cultural and social barriers in pregnancy and the post-natal period by providing culturally sensitive and linguistically appropriate information in multiple South Asian languages. The programme aimed to improve care, increase efficiency in the NHS, and support the UK economy and was due to be launched 2 weeks following our visit.

Areas for improvement

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

Action the maternity service MUST take to improve:

Maternity

- Leaders must ensure that it improves its digital care records systems to make sure that records are completed contemporaneously, in full, and data is accessible across the trust and stored safely. Regulation 17(1)(2) (c)
- The service must ensure there is a process to ensure oversight and management of policies, guidance and procedures to ensure they are reviewed in a timely manner, are clear and reflect national guidance (Regulation 12 (2) (b))
- The service must ensure they have a regular audit mechanism to demonstrate compliance with standards and procedures, to identify gaps, implement and monitor improvement (Regulation 17 (2)(a) (b)).

Action the trust SHOULD take to improve:

Maternity

- The service should ensure all staff have regular waterbirth training to include pool evacuation training and maintain records of all skills and drills.
- The service should consider developing a process for checking safeguarding concerns when women and birthing people transfer for postnatal care and support.
- The service should ensure staff have regular baby abduction prevention drills.
- The service should scrutinise data related to ethnicity and vulnerabilities and use it to design maternity services to address inequalities.
- The service should consider developing a separate data set for the birth centre, to better understand the quality and safety of care provided,
- The trust should consider reminding staff about closing sharps boxes.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors. and 1 midwifery advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.