University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary

Inspection report

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Date of inspection visit: 28 February, 01 and 02 March 2023
Date of publication: 20/09/2023

Ratings

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

Our findings

Overall summary of services at Leicester Royal Infirmary

Requires Improvement 

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 Leicester Royal Infirmary.

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

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

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

We also inspected Leicester General Hospital and St Marys Birth Centre run by University Hospitals Leicester NHS Trust. Our reports are here:

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

St Mary's Birth Centre – https://www.cqc.org.uk/location/RWE10

How we carried out the inspection

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

Maternity

Requires Improvement 

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

- The service did not always have enough staff to keep women and birthing people and their babies safe. Staffing levels did not always match the planned numbers putting the safety of woman, birthing people and babies at risk.
- The service did not always control infection risk well.
- The maintenance and use of facilities and equipment did not always keep people safe.
- Staff did not always assess and identify risks to women and birthing people and act on them. They did not always keep good care records.
- Records were not always clear, up-to-date, easily available and stored securely.
- Staff did not always manage medicines safely.
- There was some evidence of opportunities for learning from incidents; however, there was limited evidence that learning was translated and embedded into practice.
- Leaders did not always operate effective governance processes and they did not use systems to manage performance and improve the service.
- Staff and leaders did not always identify and escalate relevant risks and issues, which meant women and birthing people were put at risk of receiving poor quality and unsafe care.
- Actions to mitigate risks and make improvements were not always identified, and when identified, they were not always implemented and monitored.
- There was some evidence of safety processes, but we were not assured there was an effective and embedded safety culture within the service as staff did not always assess, monitor and manage risks.
- Staff had not always felt respected, supported, and valued.

However:

- Staff had training in key skills, and generally understood how to protect woman and birthing people from abuse.
- The new leadership team were implementing actions to improve the monitoring and oversight of the service to reduce risks and improve the quality of care provided to women and birthing people.
- The leadership team were working with staff and an external agency to understand and improve the culture in the service.
- Many staff were focused on the needs of women and birthing people and their partners and family.
- Staff understood the service's vision and were developing a strategy with key stakeholders to implement it.

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.

Maternity

Is the service safe?

Inadequate 

Mandatory training

The service provided mandatory training in key skills to staff, and we saw that for some of the training compliance was good. However, we were not provided with information about some training elements.

Nursing, midwifery, and medical staff received and kept up to date with the mandatory training items we received data for. The service supplied trust level compliance figures for the obstetric specific training, not compliance data split by location, which we had requested. This meant we could not be assured of the obstetric training compliance data for Leicester Royal Infirmary. Training compliance with PROMPT/skills and drills (which was part of the saving babies lives training day) and neonatal life support was 97%, 100% and 96% for midwives, maternity nursery nurses and maternity support staff respectively, which was above the trust target of 95%. Compliance with PROMPT/skills and drills and neonatal life support (NLS) was 90% and 97% for consultant obstetricians and junior doctors in obstetrics respectively, and 100% and 95% for consultant anaesthetists and junior anaesthetists respectively. Leaders told us midwives also had the opportunity to attend the NLS course with 4-year expiry, and there were currently 72 midwives (including some in the home birth team and St Mary's Birthing Centre) at the trust who were NLS providers.

Medical staff told us CTG teaching took place at induction and there was a test to pass. Compliance data, not split by site, showed compliances of 95%, 100% and 93% for consultant obstetricians, junior obstetrics doctors and midwives respectively for both the theory and assessment components. There were weekly CTG reflection meetings that were also recorded. Attendance figures from April 2022 to March 2023 showed that on average these were attended by 8 midwives, 6 consultants and 13 specialty trainees in a month. However, the attendance aim for medical staff was low at 2 per year. We do not know whether protected time was allocated for staff to watch recordings, and therefore whether staff not attending the meetings accessed this learning. There was an annual week of sessions on fetal monitoring in May 2022 and 2023, which staff could attend if available, but again we do not know whether protected time was allocated for watching recordings for those not attending.

Combined maternity and medical staff compliance for adult basic life support was 96.72%.

Of the 24 modules listed in the trust generic mandatory training, combined midwifery and medical staff compliance figures for 15 of the modules met the target of above 95%, 7 modules had compliance of 90-95% and 2 modules had below 90% compliance.

We could not be assured of the effectiveness of mandatory training due to the lack of data we received as part of this inspection. We requested, but did not receive, compliance for perinatal mental health (included in the saving babies lives training day), advanced life support and pool evacuation training. During the factual accuracy period the service provided information that pool evacuation training was last completed in 2019-2020, and that future training was going to be planned.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us managers emailed them about mandatory training to keep this up to date.

Safeguarding

Maternity

Staff generally understood how to protect woman and birthing people from abuse and the service worked with other agencies to do so. Most staff had training on how to recognise and report abuse, however not all staff knew how to apply it.

Most staff received training specific for their role on how to recognise and report abuse. Combined maternity and medical staff compliances were above the 95% target for safeguarding adults and children levels 1 and 2 and for safeguarding children level 3. A breakdown of compliance for 'safeguarding level 3' showed compliances ranging from 96.3 % to 100% for the different areas of the maternity service across all sites, but 88.9% for medical staff. It was not clear whether this included both children and adults' level 3 safeguarding.

We found staff did not always know how to make a safeguarding referral and who to inform if they had concerns. Some staff were able to explain the electronic referral to the safeguarding mailbox and safeguarding lead, who would forward the referral to social services as necessary. They also explained they would ring social services to check for any previous involvement. Other staff said they would discuss concerns with the midwife, who would arrange the safeguarding referral. Safeguarding concerns were logged on the electronic patient record system.

There was a baby abduction policy and staff undertook baby abduction drills. Staff told us this had been practiced last year. Ward areas were secure, and doors were monitored.

Cleanliness, infection control and hygiene

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

Maternity service areas were not always clean and did not always have suitable furnishings which were clean and well-maintained. The environment appeared generally clean and dust free overall but on Ward 6 some of the floors in the bay areas were visibly dirty. Not all curtains on the wards were disposable and some of the disposable curtains were not dated. Staff told us the fabric curtains were not cleaned routinely and that this was only done when visibly dirty.

On delivery suite, one of the shower room floors was visibly dirty (cleaned but engrained dirt), and we noted some cracked plaster. There was also a bariatric bed in the corridor with gas cylinders on it, which staff told us had been there since 2017. There was and an assortment of equipment opposite the nurses station, for example dusty letter trays. One of the emergency panels had a broken plastic cover over the oxygen valve. We reported this to staff who escalated it to estates.

The service generally performed well for cleanliness. We saw the overall scores for cleaning audits from November 2022 to January 2023. For the delivery suite these ranged from 97.2% to 99.3% and for the Orchard birthing centre from 96.8% to 100%. For the MAU scores were 100%, for Ward 5 scores ranged from 99.5% to 100%, and for Ward 6 from 99.6% to 99.8%. For theatres 19 and 20 and outside theatre areas for December and January scores were 100% in all cases. We saw one audit for November 2022 for antenatal clinic which had an overall score of 98.6%.

We saw staff following infection control principles including the use of personal protective equipment (PPE), however audit results provided as part of this inspection did not always demonstrate satisfactory compliance. We observed staff using hand sanitisers on delivery suite and adhering to the bare below the elbow policy. We saw the results of hand hygiene audits for October, November and December 2022 for delivery suite and wards 5 and 6. These showed compliance of 90% or more for these months for each area, except for delivery suite in December 2022 which had 81%

compliance. We saw infection prevention audit results between October and December 2022 for delivery suite and wards 5 and 6 which showed compliances of 90% or more except for ward 5 which was 88% and 81% for November and December 2022 respectively, and delivery suite which was 81% for October 2022. We did not see audit data for other areas of the maternity service such as triage/MAU or antenatal clinic.

Staff we spoke with did not know where to access spill kits or what these were.

Staff cleaned equipment after contact with women and birthing people. Equipment and furniture were cleaned after use and labelled to show they were clean and ready to use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste safely.

The design of the environment generally followed national guidance, however there were areas requiring improvement.

The triage/MAU was located on the first floor. There was a reception/waiting area, 2 triage assessment rooms and a 4-bed bay with a staff office and further waiting area.

There was a separate office for telephone triage located on the ground floor remote from the triage/MAU on the first floor. This meant there was complete separation of telephone triage from the triage/MAU. However, the remote telephone triage was not always staffed, which meant the triage/MAU team took the calls instead.

The delivery suite was located on the fourth floor. There were 10 rooms all with en-suite facilities. There were 2 bereavement rooms (1 accessed via the main lift area, but the call bell rang through to delivery suite), and a 4-bed bay allocated for inductions of labour. There was a 2-bed enhanced care bay. There were 2 theatres and a recovery area. There was a co-located midwifery led unit with 6 birthing rooms, 4 with en-suite and 2 which had birthing pools.

There were 2 theatres on the first floor, 1 of which was used for elective caesarean sections, a 3-bed recovery area and an arrivals area for women and pregnant people attending for theatre.

There were 2 mixed antenatal/postnatal wards on the third floor which each had a total of 26 beds arranged as three 4 bed bays, one 6 bed bay and 8 side rooms, and a nursery.

Access to the maternity wards and theatres was controlled by a receptionist. There was secure access to triage/MAU, maternity wards and delivery suite by staff card access and with monitored entry and exit system. There was an intercom but no CCTV. However, it was possible to access the theatre waiting area for people attending for procedures on the first floor without access cards.

A ward clerk told us they would ask about safeguarding concerns or visiting restrictions in the morning. They said they would ask visitors who they were visiting and take them to the bed unless busy. They did not take the names of visitors generally but if someone had visiting restrictions, for example for safeguarding reasons, staff told us ward clerks and receptionists would have the name.

The whiteboard on the delivery suite displayed the surnames of women and birthing people, this was in a patient facing area. This meant these could be seen by other women and birthing people and their relatives.

Maternity

The service had separate elective and emergency theatre lists in separate theatres with separate theatre teams. This meant that emergencies were not delayed by elective caesarean sections and vice versa. This may also reduce the risk of elective caesarean sections being cancelled.

There was an enhanced recovery pathway in place for elective caesarean sections which helped the flow of elective procedures through the service and reduced the need for cancellations of elective caesarean sections.

There were 2 emergency obstetric theatres. This meant that if 2 emergencies occurred at the same time, the service had a second theatre available, and managers told us they were able to get a second theatre team from main theatres to staff this.

Staff told us they had occasionally used the theatre recovery area as a third theatre when they had 3 emergencies at the same time. This meant the third emergency would be done in an environment not designed for emergency theatre cases. We could not be assured this was risk assessed. However, leaders told us there was a clear pathway to opening a third theatre.

We requested ligature risk assessments and managers advised that Health and Safety Services had assessed maternity as low risk, therefore had not completed detailed risk assessments of each area. However, managers had since requested Health and Safety and clinical teams to perform full risk assessments of all maternity areas. In one of the rooms on the midwife led unit we noticed a window opening cord hanging from the window, which was a ligature risk. We escalated this to management at the time.

On ward 6 there were beds stored in the main corridors within the maternity wards. This would obstruct the movement of a bed from the bay in an emergency. We were told there was no risk assessment in place for this. We saw there were some doors (bathroom and nursery room doors) being propped open with a chair or bin.

On ward 5 there was an open bottle of disinfectant on the basin in the nursery.

Staff did not always carry out daily safety checks of specialist equipment. We noted gaps in daily checks in several areas. The emergency trolley checklist log on delivery suite showed no checks for 4 days in February 2023. On delivery suite we found equipment missing on a resuscitaire, and staff also told us there were problems with checking equipment. The emergency trolley for MAU and theatres had some gaps in the daily checks between November 2022 and February 2023.

There were 2 daily checks missing in January for the ward 5 resuscitaire. There were gaps in the daily checks of the adult resuscitation trolley on ward 5 from 1 to 13 February and no documented checks for January 2023. We also found tamper proof tags were used to secure the trolley, but these had no numbers on which meant it was not possible to identify whether the tag had been removed and replaced.

Staff did not always make sure legionella prevention measures were carried out. We saw the results of the compass flushing report for the period between 5 December 2022 to 1 January 2023. This showed that for delivery suite 100% flushing was on time, for MAU 92% was on time with 8% not done, for Ward 5, 75% was on time, 8% was late and 17% was not done, for Ward 6 100% was on time and for the antenatal unit 100% was on time. It was noted at the Women's Infection Prevention Meeting in January 2023 that ward 5's flushing scores were down.

The service had suitable facilities to meet the needs of women and birthing people's families. Visiting for partners was from 9am to 9pm or on a case-by-case basis.

A separate breastfeeding room was available.

The service did not always have enough suitable equipment to help them to safely care for women and birthing people and babies. Evidence provided by the service, which was not broken down by site, showed that compliance with servicing of clinical equipment across the service was poor in many cases. For example, compliance with servicing for fetal heart detectors was 54%, for infant incubators was 33%, for non-invasive blood pressure monitors was 64%, for haemoglobin analysers was 33%, for operating tables was 20%, for pulse oximeters was 54%, for transducers was 30%, for resuscitators was 65%. There were other pieces of equipment for which compliance with servicing was 0%. These included auditory function screening devices, blood analysers and ultrasound scanners.

A lack of planned maintenance for medical equipment was entered on the risk register with an opened date of May 2009 and review date of April 2023. The effect was documented as 'reputation' with one of the consequences listed as potential for equipment to perform out of specification, leading to increased risk of patient/staff harm. In the action summary of the risk entry, it was stated all actions closed – risk tolerated, and controls monitored.

We found Wards 5 and 6 shared some emergency equipment, this meant the equipment may not be available if needed on both wards. Leaders told us they would be taking action to provide this emergency equipment for each ward.

On the maternity wards, not all beds had piped oxygen due to the layout of the building (there was only piped oxygen in recovery and 2 of the side rooms) so portable oxygen would be used if needed.

Staff disposed of clinical waste safely. The foot operated waste bins were in working order, there were separate colour coded bins for different types of waste and sharps bins were labelled correctly and not over-filled. Clinical waste bins were stored in a secure compound.

Assessing and responding to risk

Staff did not always complete and update risk assessments or take action to remove or minimise risks. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.

Staff used the nationally recognised Modified Early Obstetric Warning Score (MEOWS) to identify deteriorations in the health of women and birthing people. Staff used an electronic system to document and score MEOWS. We saw the results of maternity early warning score audits for October, November and December 2022 for wards 5 and 6 and the delivery suite. These showed an overall compliance of 100% for the completion of MEOWS in these 3 areas. Compliance data for the midwifery led unit and triage/MAU was not provided.

In triage/MAU, observations and a total MEOWS score were written on the separate triage proforma. However, this did not include the full range of parameters required for MEOWS scoring, for example amount of oxygen used, Alert Voice Pain Unresponsive (AVPU) score or urine output. This meant it was difficult to know whether the total MEOWS score had been calculated correctly and which observations were causing a high MEOWS. This meant we were not assured women and pregnant people had their risk categorised correctly.

Staff completed risk assessments for women and birthing people on arrival, but this was not consistently or reliably done using a recognised tool. Staff used a risk assessment tool based on the Birmingham Symptom Specific Obstetric Triage Score (BSOTS) for maternity triage. However, the Red Amber Green (RAG) rating part of the tool was not fully implemented. Staff used the BSOTS proforma as a prompt to help them with the assessment process, but the BSOTS guidance was not followed.

Maternity

Women and pregnant people attending triage/MAU for emergency assessment were not always seen by a doctor within the RAG rating time frame. This does not include the smaller group of people attending triage/MAU for day assessment or postnatal care, which does not require triage using the RAG rating assessment times. We were not assured that arrival and assessment times were being recorded accurately, which then could impact on RAG rating times. Staff told us the 'arrival in triage' time was when the maternity care assistant (MCA) completed basic measurements, and 'initial triage assessment' was when a midwife completed the triage assessment. Staff told us the time of arrival in triage reception was recorded in a separate paper logbook. This meant it was not clear when the clock started. Evidence provided as part of this inspection showed for delay between presentation and triage during the 6-month period August 2022 to January 2023, only 2 red flags had been reported.

We reviewed records on both the BSOTS proformas and the log- book and found the different times for different stages of the process and RAG ratings were not always recorded. We saw inconsistencies between the BSOTs sheets and the logbook. We also saw cases where doctors did not review women and pregnant people within the required timeframe according to the RAG rating. There were some cases where there were 2 different RAG ratings. Overall, this meant we were not assured that women and pregnant people were being seen within the correct timeframes. It also meant we were not assured it would be possible to accurately audit triage/MAU waiting times.

We saw the results of an audit of triage records across both sites from July 2021 to November 2021. This showed that of the 249 records audited, for 242 records, the BSOTS paperwork had not been fully completed. Only 176 women and pregnant people had been categorised with a RAG rating, and of these only 121 had been categorised correctly.

Staff told us the service had tried to implement BSOTS 3 times but had not been successful due to staffing. We saw an action plan for this audit with deadlines of April and May 2022, and BSOTS was relaunched in June 2022 with a plan to re-audit 2 months afterwards. We saw evidence of a plan to form an implementation team to successfully re-launch BSOTS. However, there had been no further triage audit since the 2021 audit and the re-launch of BSOTS had not been successful.

Staff did not always know about and deal with any specific risk issues. The telephone triage service used an electronic notes system that recorded previous calls and safeguarding information. However, the information about previous calls was not flagged, and the user would need to look specifically for this and other risk factors, although there were safeguarding alerts.

There was no system to monitor the number of calls to telephone triage or the number of abandoned calls. This meant there was no oversight of the workload and service capacity needed, and no oversight of people who were not able to get through to telephone triage.

Staff in telephone triage said they would try to re-contact women and pregnant people who had not attended within 4 hours of being advised to come into triage, however, we could not be assured this was done in all cases.

The number of women and pregnant people in triage/MAU and their level of acuity did not feed into the daily tactical/ operational meetings, only staffing numbers did. This meant the full extent and nature of activity on triage/MAU may not be fully understood and therefore acted upon in a timely manner. Triage/MAU took referrals from antenatal clinic (for example women and pregnant people with reduced fetal movements) and cared for women and birthing people in labour if the delivery suite was busy. This meant the acuity on triage/MAU would be increased.

Following concerns, we raised about triage/MAU, the trust had started to implement mitigations.

Maternity

Staff used a 'fresh eyes' approach to fetal monitoring. 'Fresh eyes' is a checking system that uses peer review to give a second opinion on CTGs. However, the process was not consistent, with fresh eyes stickers being used in different ways. Some stickers stated just 'yes' for fresh eyes, and some midwives used a separate sticker for their fresh eyes assessment.

The service had been using the International Federation of Gynaecology and Obstetrics (FIGO) guidelines for CTG interpretation for over 10 years. They recognised that non-classification could be an issue but were able to justify their reasoning.

We also observed some staff talking about CTGs in an unclear way. Staff were not classifying the CTGs in line with FIGO (International Federation of Gynaecology and Obstetrics) guidance, instead they were using subjective descriptive terms such as 'really bad' or 'not really bad' or 'late decels'.

The service changed to hourly fresh eyes in April 2022 to move in line with national guidance. Between September 2022 to February 2023, we saw compliance with fresh eyes ranged from 62% to 100% (62% in September and 100% in December) Number of records reviewed for these monthly audits ranged from 10 to 40. We did not receive action plans for the fresh eyes spot check audits to improve compliance. However, we were told spot check audits, which included fresh eyes and hourly assessment of the fetal heart, were discussed at band 7 midwife meetings, and leaders provided evidence of a presentation in December 2022 shared with staff as a reminder of fresh eyes requirements. However, we were not assured these measures and programme of spot check audits were adequate and effective, because although compliance was 90% in February, this was based on only 10 records, and compliance was 81% in January 2023 based on 24 records.

Compliance with hourly assessment of the fetal heart ranged from 86% to100% from September 2022 to February 2023.

We observed the World Health Organisation (WHO) maternity surgical safety checklist had a clear sign in and time out in theatre for an emergency case. We requested, but did not receive, a WHO checklist audit. We received only data from the electronic theatres system stating whether the WHO sign in, sign out and time out had been done or not, and stating whether the WHO was compliant or not. However, we were told audit results were recorded under the site, not by specialty which meant the audit data was not meaningful for this inspection.

The service had not completed any Newborn Early Warning Trigger and Track (NEWTT) system (a system for detecting when newborns are becoming unwell and triggering an early medical review) or situation background assessment recommendation (SBAR) (a system used to give a structured handover containing all the important information) audits. However, during the factual accuracy process the service told us the NEWTT audits were paused during the COVID-19 pandemic. They were now planning to use the British Association of Perinatal Medicine (BAPM) updated NEWTT 2 system and said they would audit this in 2023/2024.

Evidence submitted as part of this inspection stated there had been a gap in auditing since October 2022 due to recruitment of a new audit midwife, and the service was working on the audit backlog. However, leaders told us Ockendon and Saving Babies Lives audits were prioritised and we saw evidence that these had continued during this time.

We reviewed 3 sets of records and found they were generally fully completed including venous thromboembolism (VTE) risk assessments and fetal growth.

Maternity

We saw spot check audits of records (ranging from 40 notes to 12 notes) between September 2022 and January 2023. These showed intrapartum risk assessment compliances ranging from 67% to 100%. Compliance with post-partum haemorrhage risk assessments for the same months ranged from 42% to 100%.

Audit results (not broken down by site) showed compliance with risk assessment at every contact during pregnancy for November 2022 to January 2023 ranged from 94% to 100%.

The service provided red flag sepsis data for August 2021 to January 2023 (not broken down by site). This showed a total of 65 red flag sepsis cases for the year 2021-2022 and 65 for the year-to-date 2022 to 2023 (up to January 2023). We saw an audit of intravenous (IV) antibiotics given within 1 hour for sepsis. This looked at 30 cases across delivery suite, MAU, wards 5 and 6 and obstetric theatres. Compliance with giving IV antibiotics within 1 hour was 100% for MAU, and wards 5 and 6 but 67% for delivery suite (and there were no cases in theatres).

Managers told us compliance for carbon monoxide monitoring at booking was 85-90% and at 36 weeks was 70-80%. They said there was a new inpatient and community pathway in place to support this, nicotine replacement advisors in post from March 2023 and additional CO monitoring equipment had been ordered for antenatal clinics to support the inpatient pathway. Data supplied showed that from November 2021 to January 2023 smoking at time of delivery rates were on average approximately 9%.

There was a 2 bed HDU bay on delivery suite which meant the service could care for people requiring enhanced maternity care. Managers told us midwives completed an enhanced maternity care training day and that they were re-introducing practical competencies. We were told the HDU bay was typically staffed by 1 enhanced maternity care midwife and up to 2 registered nurses.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff told us for urgent mental health conditions they could contact the mental health crisis team which was available 24 hours a day 7 days a week. However not all staff we spoke with were aware of this. Staff completed psychosocial risk assessments for women and birthing people. We saw that a mental health assessment using the Whooley questions (questions that screen for depression) had been completed in the records we looked at (3 records).

Shift changes and handovers generally included the necessary information to keep women and birthing people and babies safe, but it was not always structured. We attended the morning medical handover and found it was multidisciplinary including obstetrics and anaesthetics and we observed introductions. However, there was no midwifery presence until later in the meeting (labour ward coordinator), and they were not introduced. There was no clear structure to handover and no prioritisation of discussion of patients, which was by room number not clinical priority.

On the antenatal and postnatal wards there was a verbal handover based on an electronic system drop down list, but no discernible handover with information documented and no official tool was used. For example, the handover of a woman or birthing person to delivery suite for induction of labour used prompt questions on the electronic system. Staff told us there would be a summary of the shift for each woman and pregnant person on the electronic system.

The service did not have a dedicated transitional care unit and babies requiring additional care such as intravenous antibiotics would need to go to the neonatal unit for this.

Leaders did not always monitor waiting times and make sure women and birthing people could access emergency services when needed and receive treatment within agreed timeframes and national targets.

Maternity

The service did not audit inductions of labour (IOL) but monitored them in the daily tactical meeting and documented red flags on the Birthrate Plus intrapartum acuity tool to inform site acuity levels. However, staff told us that delays once IOL had been started, for example at the point of being ready for artificial rupture of membranes (ARM), were not reported as incidents. 'This meant we were not assured the service had robust oversight of the associated risks or that the reasons for delayed IOLs were being reviewed and actions taken to reduce risk and improve this area of the service.'

Staff told us that inductions of labour were paused due to staffing levels and women were offered the option of going home during the pause. Other factors which contributed to delays included bed capacity and the level of activity within the service.

We observed a category 2 emergency section which did not seem to generate the required urgency, and there was a lack of clear communication with theatres and the laboratory for blood results awaited, which resulted in delay. The procedure was not completed in the required time frame (decision made at 0940 and knife to skin at 1205). This was not in line with the Royal College of Obstetrics and Gynaecology (RCOG) national standard of 75 minutes. The coordinator noted this and said they would address this with the team, however, some staff we spoke with did not know the required timeframes for a category 2 section. However, we observed a situation where the theatre team was alerted to the need for 2 simultaneous emergency cases and saw that the theatre lead achieved clear and efficient communication that enabled a smooth process.

The junior doctors covering MAU during the day did not have pagers, which meant staff had to rely on calling their mobile telephones. This meant it may not be possible to get through depending on the signal.

Staff in the midwifery led unit told us they had not had pool evacuation training or drills since the initial maternity training and had not seen a pool evacuation. The policy on pool evacuation was unclear and staff were unsure of the correct procedure.

Midwifery Staffing

The service did not always have enough staff to keep women and birthing people and their babies safe. Staffing levels did not always match the planned numbers, putting the safety of women and birthing people and babies at risk.

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

We saw data for midwifery staffing between November and December 2022 and found the vacancy rate for registered midwives was 13% and 14% against the trust target of 10%, and sickness rates were 6% and 10% respectively, against the trust target of 3%. For midwifery support staff we found vacancy rates were between 13% and 7% and sickness rates between 10% and 12%. Leaders cited the wider impact of the pandemic as a factor making it difficult to meet vacancy and sickness rate targets and told us these targets were very ambitious.

The Birthrate Plus acuity report for 2022 stated there were 54.1 whole time equivalent (WTE) midwifery vacancies. A breakdown of acuity RAG status for the 3 periods March to June, June to September and September to December 2022 (which only captured patient activity on delivery suite) showed that staffing met acuity for between 23% and 32% of the time. The remainder of the time the service was 3.5 whole time equivalent midwives short or even more. Unexpected staff absence or an inability to fill vacant shifts were the staffing factors with the highest recorded numbers.

Maternity

The service used a birth rate acuity tool which was completed 3 times per day and highlighted red flags. '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'. However, there were locally determined flags around delays in continuing IOL and the delivery suite coordinator not being supernumerary, and leaders told us time limits for capturing delays in starting IOL, giving pain relief and being triaged after arrival were not embedded within reporting. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. For the 6-month period between August 2022 to January 2023, a total of 1002 red flags were reported. The majority of red flags were about delays in induction of labour (IOL), with 656 red flags for delay in continuing IOL, and 59 for delay between admission for IOL and beginning of the process. For delayed or cancelled time critical activity there were 231 red flags. There were other red flags for missed or delayed care, delayed recognition of and action on abnormal vital signs, an occasion when 1 midwife is not able to provide continuous 1:1 care during established labour, and for delivery suite coordinator not being supernumerary.

Managers told us staffing on the antenatal and postnatal wards was challenging generally, and there were frequently 5 staff instead of the planned 7 during the day, and 3 staff overnight instead of the planned 5. During the factual accuracy process leaders told us there was a shortfall of 1 MCA in the planned staffing on ward 5 during the day on both days of the inspection, but that both ante- and postnatal wards had the planned staffing overnight. However, on the second day of the inspection staff told us there were only 4 midwives on ward 6 and 1 of these midwives was redeployed to triage/MAU due to high activity levels there, reducing the number on ward 6 to 3 midwives.

On the first day of the inspection leaders told us the labour ward coordinator was supernumerary throughout and all women received 1 to 1 care in labour. However, on the second day, the acuity was reported as red on 2 occasions in the evening. Red acuity means there are not enough staff to manage the level of care required by the women and birthing people in the unit. Whilst on site for the second day of inspection, we were told there were only 12 staff covering the whole service overnight, including the ante- and postnatal wards, MAU/Triage, delivery suite and the MLU, and there were 18 patients on the delivery suite alone. However, managers had escalated this and were able to find additional staffing before the start of the shift. This was provided by the home birth team, and leaders told us all women and birthing people received 1 to 1 care.

The planned staffing on triage/MAU was 3, however, staff said they did not always have an MCA covering triage/MAU, leaving just 2 midwives. One of these midwives would need to cover the telephone triage line if there was no protected telephone triage midwife on a given day. Staff reported there could be up to 30 women or pregnant people attending triage/MAU over the course of the day.

On days when there was a protected telephone triage midwife, this midwife managed 3 telephone lines, which were used by different groups to contact triage (women and pregnant people, emergency department, GPs, community midwives).

Leaders generally calculated and reviewed the number and grade of staff, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance but were not always able to achieve the required cover. The service used the Birthrate plus acuity tool to assess staffing and acuity. The morning medical handover included a discussion about midwifery and neonatal unit staffing levels.

There was not always a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. There were 32 red flags when the delivery suite coordinator was not supernumerary for the months August 2022 to January 2023. During the factual accuracy process the service told us they were acting to better understand the red flags so they could take appropriate action.

Maternity

Ward managers did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people.

We were told that if triage/MAU was busy, the protected telephone triage midwife would be required to complete electronic discharges. This was a risk because it meant staff who had not been involved with the care of women and pregnant people were completing paperwork for them. We were also told the protected telephone triage midwife would typically be moved to triage/MAU when it was busy.

Managers requested bank staff familiar with the service. Staff told us they used staff who regularly worked at the service to cover staffing gaps. Leaders told us that before March 2023 the service used only bank staff but now used 1 agency nurse at this site once or twice per week. They had increased the use of agency and bank midwives and enhanced bank rates as one way to address staffing shortfalls. They had also paused maternity continuity of carer in response to staffing levels.

The service recognised the need to improve staffing and had put in place a recruitment and retention midwife for the site. Other measures taken to try and improve staffing in the more immediate to near future included an incentive payment scheme, working with the NHS return to practice scheme and recruitment to nursing posts to support enhanced nursing care.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Compliance with appraisals across the service was between 62% and 100%. During the factual accuracy process leaders told us the 2 lowest compliance figures were due to new managers starting work. While not all staff had received an appraisal, leaders said staff development and training opportunities were an ongoing process throughout the year.

There was evidence that managers made sure staff received specialist training for their role. Staff told us there was an enhanced midwifery care staff member on each shift. This meant they could provide an enhanced care bay on delivery suite together with nurse colleagues.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to keep woman and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep women and birthing people and babies safe. The medical staff did not always match the planned number.

Data provided for maternity services across all sites showed that the budget was for 28.75 whole time equivalent (WTE) consultants, and 25.24 WTE were in post. For middle grade doctors the budget was 38.05 WTE, with 43.79 WTE in post. For doctors below middle grade, the budget was 9 WTE, with 9.81 WTE in post.

There was 1 consultant covering delivery suite and 1 covering elective caesarean sections. There was also a consultant covering triage/MAU and the wards, clinic, and the scan room daily. Managers told us there were no gaps in the consultant rota at Leicester Royal Infirmary.

Managers told us all obstetric areas requiring junior doctor cover over the last 6 months were staffed as per the required staffing levels without leaving any vacancies. However, the required levels were not always adequate. For example, we

found triage/MAU did not have protected medical cover. This meant there were competing demands on doctors between triage/MAU and the wards, and staff told us it was difficult to get doctors because they were doing ward based work as well. This meant women and pregnant people attending triage/MAU may not be seen by a doctor in the appropriate time frame.

We found multiple examples of incidents on the national reporting and learning system (NRLS) demonstrating delays to care due to doctors not being available. Some of these delays were very long (for example 6 hours) and some resulted in women and pregnant people self-discharging before medical review. This was a risk because women and pregnant people assessed as needing a medical review were not being seen by a doctor.

Out of hours junior doctors provided cover and oversight across all areas of maternity, but also gynaecology.

The service did not always have a good skill mix and availability of medical staff on each shift. Staff told us that sometimes there was only a Foundation Year 1 (FY1) doctor, (and sometimes there may be 2 FY1 doctors) covering triage/MAU and the antenatal/postnatal wards. We noted some staff referred to the FY1 doctor as a senior house officer, this raised concerns that some staff thought some junior doctors were more experienced than they were.

Data submitted by the service together with information from staff during inspection showed that FY1 and Foundation Year 2 (FY2) doctors were used interchangeably with more experienced doctors as though they were equivalent. For example, information submitted for medical cover showed that the doctor covering triage/MAU or delivery suite may be an FY1.

FY1 doctors are doctors in their first year of employment following completion of their medical degree and are registered with the General Medical Council with a provisional licence to practice only and should be supernumerary due to the specialised nature of obstetrics. This is not usual practice, however, should be risk assessed and appropriate and enhanced supervision provided.

The service always had a consultant on call during evenings and weekends. There was a consultant resident until 10pm during weekdays and until 5pm at weekends, and then available on call from home. The on-call consultant covered MAU, delivery suite, the maternity wards and emergency department.

There were daily consultant led ward rounds in the morning, however there was not always a consultant led ward round in the evening, and the required professionals were not always present. We saw sign in sheets for 21 February to 1 March 2023 for attendance by the obstetric consultant, anaesthetist and labour ward coordinator at ward rounds morning and evening. This was complete for mornings but not for evenings, which had only 4 evenings completed for the same period. Staff told us consultant led ward rounds did not always happen in the evenings. Audit results for compliance with consultant led ward rounds, twice daily, 7 days per week (compliance needs the consultant, anaesthetist and coordinator to be present as a minimum) ranged from 60% to 73% for November 2022 to January 2023. Staff told us there were plans in place to improve this.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors told us there was always someone to speak to, they could always get support for learning objectives and help, senior support was good, and it was easy to escalate concerns. They said there was a list of when consultants were expected to be called and when expected to attend and all staff clear about this, with no problems with escalation.

We requested appraisal data for all staff, however only received figures for consultants across all sites. These showed 15 were compliant, and 9 were compliant with upcoming renewal.

Maternity

Records

Staff kept records of woman and birthing people's care and treatment. Records were generally clear and up to date but were not always stored securely and not always easily available to all staff providing care.

Women and birthing people's notes were not always comprehensive and easily accessible to all staff. The service used a combination of electronic and paper notes. Risk assessments such as VTE, MEOWS and handover information were on an electronic system. There was a different electronic system for triage/MAU notes and safeguarding concerns (E3). The RAG rating assessment in triage/MAU was completed on a paper proforma and midwives and doctors wrote on this. Inpatient notes were paper. Therefore, there was no single point of overall visibility for staff. This meant there was a risk important information would be missed.

The service had not carried out a records audit, which meant they could not be assured about the quality of their record keeping was. Managers told us there was a working party looking into auditable criteria across the digital and paper records.

Records were not always stored securely. Paper records were generally kept in a locked keypad trolley, however the digital locks on the notes trolleys on ward 5 were non-functional (battery discharged on 1 and lock broken on the other, this had been noted in November 2022 but had not yet been fixed). The baby notes trolley on ward 5 had 4 stickers around it showing the pass code to access the notes trolley and the room in which these were kept was not locked.

Medicines

The service generally used systems and processes to prescribe, administer, and record medicines but they were not always stored safely.

Staff generally followed systems and processes to prescribe and administer medicines safely. The service used electronic prescribing.

Staff generally completed medicines records accurately and kept them up to date. We reviewed 7 prescription records and found that staff had completed these correctly except that not all medications omitted or not given had a reason for omission documented.

Across the wards the medicines trolleys were disorganised. For example, liquid medicines lacked either date opened or in-use expiry dates, strips of medicines were no longer in the outer cartons and patient specific medicines were mixed with stock medicines.

On Ward 6 milk fridge temperatures were not recorded (nothing after 3rd January for rest of January) and we found some out-of-date milk in the milk room and expressed milk did not have patient id stickers. This meant the wrong expressed breast milk may be used if people had the same name. On ward 5 milk fridge temperatures were taken but we found some out-of-date breast milk in the fridge.

Incidents

Maternity

The service generally managed safety incidents. Staff generally recognised and reported incidents and near misses, except for some that were not routinely reported. There was some evidence that managers investigated incidents and shared lessons learned. When things went wrong, staff told us they apologised and gave women and birthing people honest information and suitable support.

Staff generally knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. However, there were some issues that were not routinely reported as incidents, for example delays during IOL'

There was some evidence that managers reviewed incidents so that they could identify potential actions. We saw summaries of 51 cases of perinatal death reviewed by the Perinatal Mortality Review Group (PMRG) using the perinatal mortality review tool (PMRT) for the period July 2022 to December 2022. We saw 22 cases had learning or actions identified, whereas for others there was no learning or actions, or other reports or further discussion were awaited.

A February 2023 report to the Mortality Review Committee (MRC) on neonatal mortality in 2020 proposed a plan including reviewing all 2022 neonatal deaths, a peer group neonatal mortality review meeting and a further report to the MRC including outcomes from these actions.

The minutes of the Perinatal Risk Management Group meetings for November 2022, December 2022 and January 2023 showed cases were discussed and actions generated from this. We saw examples of recommendations following reviews.

We saw summaries of the learning and actions from completed HSIB and serious incident reports for October, November, and December 2022. For all 6 incidents the family had either been offered a meeting or had met with the trust.

There was some evidence managers shared learning with their staff. We saw examples of serious incident learning bulletins which included a summary of what happened, what had been learned, recommendations for prevention and any actions staff needed to take, as well as the contact details of the Patient Safety Coordinator.

There was some evidence staff reported serious incidents in line with trust policy. Between August 2022 and January 2023, we saw 5 serious incidents had been reported to the strategic executive information system (STEIS) and 2 had been reported to the Healthcare Safety Investigation Branch (HSIB). There were other open incidents at various stages of the investigation process and some of these had safety recommendations.

Staff told us they understood the duty of candour, and that they were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. We saw examples of trust serious incident investigation reports between 2021 and 2022 (6 reports) which stated that duty of candour discussions had taken place and formal duty of candour letters had been sent.

Staff received feedback from investigation of incidents. Staff told us there was a risk midwife who reviewed incidents and passed on any actions from these to the teams. They also said there was a newsletter on themes in maternity that was emailed once per month.

Some staff met to discuss the feedback and look at improvements to the care of women and birthing people. Staff told us a family and friends survey was given to all women and birthing people at the time of discharge to collect feedback, and there were 'message to matron' cards. There was a shared decision-making council which had recently been introduced. This involved core staff discussing ideas to improve patient care and staff wellbeing. The council would then summarise this information and email it to staff.

Managers told us there were monthly ward meetings where new guidelines, incident themes, complaints and extra training would be discussed. However, some staff told us they were not aware of any sessions where incidents were discussed.

There was some evidence that changes were planned following feedback. We saw examples of action plans resulting from the investigation of HSIB cases and serious incidents. However, there was no evidence that managers looked at incidents by ethnicity to identify themes and trends.

Managers debriefed and supported staff after serious incidents.

Is the service well-led?

Requires Improvement ↓

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

Leadership

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

The chief nurse led a review of the maternity leadership structure and had restructured the leadership team 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 matrons (rather than cross site), and newly created specialist positions.

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. The increased leadership team was created to improve oversight and safety of maternity services and support a culture of assurance rather than reassurance.

The DoM had commenced in January 2023 and at the time of our inspection were supported by 1 HoM. An additional HoM post had been created and was due to commence in 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 to ensure the service had the right staff. The review commenced 3 weeks prior to our inspection and was due to be completed by the end of March 2023.

Maternity

At the time of our inspection there were 2 live adverts, 1 for an additional matron to act as the named midwife for safeguarding; and another for site specific maternity service co-ordinators to provide 24-hour cover 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, we found the DoM understood the issues and was prioritising the main risks even though they had been in post for less than 2 months. The senior leadership team and clinical management group had planned time to focus on working together and developing as a team. An external company had been commissioned to facilitate this time together. They were committed to working together as well as with the rest of the trust, and external agencies and bodies 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. The board safety champions engaged with staff and service users on walkabouts, to obtain views on safety. The 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. Following staff feedback this monthly drop continued online, to ensure it was accessible to all.

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.

Maternity services reported directly to the board since May 2022. Monthly maternity performance indicators were reviewed by the board. 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). We saw a parent story was presented to board at the January 2023 meeting. Monthly maternity performance indicators were reviewed by the board. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies.

Leaders were visible and approachable in the service for women, birthing people, and staff. The executive team visited wards on a regular basis. Leaders were well respected by staff who described them as approachable, and supportive. Staff spoke highly of the new DoM, and the additional senior positions. During the factual accuracy process the service told us that both the clinical director and DoM worked clinically to support staff engagement, however, this was not articulated by staff during our onsite inspection.

Leaders encouraged staff to take part in leadership and development programmes to help all staff develop their skills and take on more senior roles. Several staff had been supported to complete a leadership programme.

Vision and Strategy

The service had a vision in draft 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, birthing people and babies.

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

Maternity

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 promoted equality and diversity in daily work and 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.

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. This was also reflected in some enquiries we had received, and the tone of some reported incidents. However, we could not see culture on the maternity risk register.

Staff survey results were not always positive. For example, the response to the of junior doctor's national survey (2022), at Leicester University Hospital showed that 72.8% were happy with their induction, 52.1% reported working in a supportive environment and only 29.1% said they were happy with the rota design. The clinical director was meeting with junior doctors and educational supervisors (separately), to explore the results further, and look at how support could be optimised.

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 who were site specific to each location, including community services. 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 an external project called Empowering Voices (EV), to understand and address the cultural issues across all 3 locations, including community, and focus on what mattered to staff. 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. Staff were supported 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.

The service was also undertaking other work which 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.

Maternity

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. During the factual accuracy of process, the service informed us that they had applied for Institute for Healthcare Improvement's Pursuing Equity programme, however it was difficult to understand the impact of this work at the time of our inspection.

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 from the listening exercise 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. However, despite this significant piece of work which was completed in June 2022, key recommendations had not been considered or progressed.

Managers investigated complaints and identified themes and shared feedback with staff. Learning was used to improve the service. Complaints were a fixed agenda item on every team meeting. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Staff were focused on the needs of women and birthing people receiving care and showed respect for them as individuals. We saw evidence that the Duty of Candour (DoC) was practically met for serious incidents. Staff used a sticker which included prompts to support staff in the application of DoC, and monitored compliance to ensure it was always applied.

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 told us they wanted to improve governance processes throughout the service, and with partner organisations. The director of midwifery (DoM) had reviewed the governance process and 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 women's governance board reported to the maternity assurance committee which was chaired by the chief nurse. The maternity assurance committee reported to the quality committee who reported directly to the trust board. The

women's governance board met monthly. It was not site specific, and it did not always monitor data specific to each location. Data was often amalgamated, which made it difficult to identify site specific issues and areas in need of improvement. It was not clear from meeting minutes who the chair was, and although there was representation from a consultant obstetrician and neonatologist, there was no anaesthetic representation.

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. Progress had been made with compliance in a further 2 safety actions. Actions for all standards with partial compliance were in progress.

The service did not have approved pathways of care into transitional care jointly approved by maternity and neonatal teams. There was no focus on minimising separation of mothers, birthing people and babies.

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. 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 out-of-date, not in line with national recommendations, 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. Equally, we saw that safety recommendations following Healthcare Safety Information Branch investigations, often related to guidelines.

Managers and staff did not carry out a comprehensive programme of audit to identify gaps, monitor change, and drive improvement. There was a general lack of oversight and monitoring of systems and process throughout maternity. This meant managers were not always aware of risk and level of risk, and meant it was difficult to prioritise improvements and implement change.

In addition, the trust did not always separate data for all 3 locations. This meant they were unable to quickly identify, monitor and implement improvements for site specific issues.

An independent desktop review of the maternity services' governance systems, themes and trends was commissioned by the local Clinical Commissioning Group in 2022. The review recommended that maternity services invest greater time to describe and understand the story of women and birthing people that reports related to. This was to enhance the learning and benefit families more. The work with the MVP had been paused throughout the pandemic and was about to re-launch at the time of our inspection.

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 staff survey for 2021 (published in February 2023), 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.

Senior staff presented cases for perinatal risk in a variety of learning arenas, and fetal monitoring leads used cases from incidents to share learning at regular multi-disciplinary forums. However, clinical midwives were generally unable to attend learning forums due to insufficient staffing numbers and high acuity.

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. Learning form incidents was also weaved into mandatory training. 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.

Maternity

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.

Leaders did not always identify and escalate relevant risks and issues and actions to reduce their impact. During our inspection we found evidence the trust did not always assess nor do everything reasonably practicable to mitigate risks to women, birthing people, and babies across the maternity pathway and especially those attending the maternity assessment unit and triage. Although some improvements had been made since the recent appointment of the DoM, when we visited, we found several risks that had not been assessed or mitigated.

Daily operational / tactical meetings considered staffing numbers but not the number or acuity of women and birthing people who attended the maternity assessment unit and triage. No red flags were recorded for a delay between the presentation of women and birthing people and their triage. However, this was not consistent with incidents reported, our observation on site, staff feedback and our review of care records. This showed a lack of oversight and meant mitigations were not implemented to manage associated risks.

During the factual accuracy process the service provided additional information which it hoped to address medium to longer term staffing concerns. These included supporting staff through midwifery education including the short course for registered nurses to train to become midwives. Due to the increase in pre-registration midwifery students the service told us they had implemented strategies to increase capacity in placement areas to ensure students have supportive practice placements.

There was one risk register for all 3 locations. We found some examples of significant risks that were not being managed and which we had to highlight. This included lack of monitoring of a high-risk baby on the postnatal ward and lack of oversight of acuity and risk in triage.

We found some examples of risks that were known, but not being managed. These included the risk that junior doctors (F1) were not always supernumerary, the risk of women and birthing people sometimes self-discharging from triage (due to waiting time), without any follow up, and guidelines that were in use that were out-of-date and did not reflect national recommendations.

Although the senior leadership team told us triage was one of their highest risks and they had a firm plan to move telephone triage to a single point of contact off-site, this was not recorded on their risk register, they had not monitored their drop-off calls, and nothing was in place to mitigate risks until the plan came to fruition. We raised our concerns with leaders following our inspection and we were the trust provided an action plan and evidence which showed they had expediated their current plan at pace, to mitigate the risks.

Information Management

The service collected reliable data and analysed it. Staff could not always easily access patient information and data was not always used to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

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

internal benchmarking and comparison. Recruitment and retention were their highest risk. The recruitment and retention team had started to produce regular infographics to display key information. This included the number of vacancies, and how many shifts had been filled by bank staff. This helped staff to understand what had been achieved, and what was planned.

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 labour ward staff was 89.0% and 100% for staff working in antenatal clinic.

Information systems were not integrated, and staff sometimes had difficulty navigating their way around the system, to find relevant information. Staff wrote in handheld notes and then duplicated information in electronic notes, which created opportunities for error. Staff did not always transfer information to electronic records due to time constraints. 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. However, they were surprised to hear that staff seemed unfamiliar with navigating the system. They advised this had not been previously raised as a concern, and there had been no related incidents.

We were told 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 and handheld electronic devices. These devices linked between maternity systems and allowed access to necessary data.

Data or notifications were consistently submitted to external organisations as required. This included the National Neonatal Audit Programme, MBRRACE-UK, and Healthcare Safety Information Branch. They had also completed the national perinatal review tool since the launch. This helped to ensure consistency of reporting nationally.

Managers told us they collected data to support higher risk women and birthing people at all booking appointments. This included ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age, and co-morbidities. There was some evidence of how it had been used to plan and tailor services.

Maternity services were in the upper 25% of all organisations where women and birthing people had a postpartum haemorrhage (PPH) of 1500mls and over or had a preterm birth. Some action had been taken including the introduction of a preterm service and PPH cases were reviewed. There was also a risk assessment tool to help identify women and birthing people at risk of PPH, although this needed additional work. A review of all maternal deaths, stillbirths and neonatal deaths in black women and babies since 2017, was also in progress. No themes or trends had been identified at the time of our inspection.

Engagement

The 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.

Maternity

Leaders had plans in place 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 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, and the service collected data on ethnicity. During the factual accuracy process the service provided some evidence which showed some data had been used to plan services to tackle inequality.

The service made interpreting services available for women, birthing and pregnant people and were trialling an app to support interpreting at the time of our visit. However, staff sometimes used family to interpret and were not always clear about how to contact or book an interpreter.

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. The Healthcare Safety Investigation Branch attended to discuss 'Learning So Far', and a law firm attended to present on 'Achieving a Culture of Candour.'

The leadership team were largely new and embedding at the time of our visit. However, they showed a 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.

The service had achieved stage 2 in the United Nations Childrens Fund (UNICEF) baby friendly initiative standards and were working towards full accreditation.

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 by providing culturally sensitive and linguistically appropriate information in multiple South Asian languages. The app was planned to be launched end of March 2023.

The perinatal mental health team included a consultant obstetrician, a specialist midwife, and a specialist mental health nurse. 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.

Maternity

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.

Outstanding practice

We found the following outstanding practice:

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

Action the service MUST take to improve:

Maternity

- The service must ensure ligature risk assessments are completed for all areas of the service (Regulation 12 (1) (2) (a)(b)(d)(e)).
- The service must ensure daily safety checks of specialised equipment are carried out (Regulation 12 (1) (2) (e)).
- The service must ensure legionella prevention measures are carried out and in a timely way (Regulation 12 (1) (2) (a)(b)(d)(e)).
- The service must ensure all clinical equipment has up to date servicing records (Regulation 12 (1) (2) (e)).
- The service must ensure all staff follow infection control principles (Regulation 12 (1) (2) (a)(b)(d)(e)).
- The service must ensure women and pregnant people are triaged and reviewed by a doctor in the required time frames according to clinical urgency (Regulation 12 (1) (2) (a) (b)).
- The service must ensure all maternity risk assessments are completed to ensure risks are mitigated (Regulation 12 (1) (2) (a) (b)).
- The service must ensure audits of key performance areas are completed and acted upon (Regulation 17 (1) (2)(a)(f)).

Maternity

- The service must ensure staffing levels are adequate for clinical need and acuity of the service and with the appropriate skill mix (Regulation 18 (1)(2)(a)).
- The service must ensure all medicines are stored safely and appropriately (Regulation 12 (1) (2) (g)).
- The service must ensure staff always use interpreters for non-English speaking women and birthing people. (Regulation 12 (1) (2) (a) (b)).
- 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)).
- The service must ensure the immediate mitigations put in place following our concerns related to governance and oversight of triage continue to be implemented and continue to be monitored (Regulation 17 (1) (2) (a) (b) (f)).
- The service must improve the overall management of governance to ensure there is effective oversight, monitoring and management (Regulation 17 (2) (a) (b) (c) (d) (ii) (e) and (f)).
- The service must improve the culture and ensure staff are actively encouraged to raise concerns and report incidents and ensure the workstreams generated from the Empowering Voices project comes to fruition (Regulation 12 (1)(2(i)).

Action the service SHOULD take to improve:

Maternity

- The service should ensure all staff have completed safeguarding adults and children Level 3 and know how to make a referral and who to inform.
- The service should ensure all areas are clean and free form clutter and obstructions.
- The service should ensure doors are not propped open to comply with fire safety requirements.
- The service should ensure all staff receive an annual appraisal.
- The service should ensure records are stored securely.
- The service should scrutinise data related to ethnicity and vulnerabilities and use it design maternity services to address inequalities.
- The service should consider developing a separate data set for each location to better understand the quality and safety of care provided.
- The service should consider providing the bereavement specialist midwives with a dedicated office to maintain complete privacy and confidentiality during calls with family.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, 1 obstetric specialist advisor and 2 midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.