University Hospitals of Leicester NHS Trust

Leicester General Hospital

Inspection report

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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 General Hospital

Requires Improvement 

University Hospitals of Leicester NHS Trust was created in April 2000 with the merger of the Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. University Hospitals of Leicester NHS Trust is one of the biggest and busiest NHS trusts in the country, serving the one million residents of Leicester, Leicestershire, and Rutland and increasingly specialist services over a much wider area.

The trust has a Children's Hospital and one emergency department on its Leicester Royal Infirmary site and 126 inpatient wards across the trust: 1,991 inpatient beds, including 200 day-case beds and 179 children's beds. Each week the trust runs 1,224 outpatient clinics. The trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, Extra Corporeal Membrane Oxygenation (ECMO), cancer and renal disorders reach a further two to three million patients from the rest of the country.

The trust also provides services from 20 other registered locations including St Mary's Birth Centre.

The trust operates acute hospital services from three main hospital sites:

- Leicester Royal Infirmary.
- Leicester General Hospital.
- Glenfield Hospital.

The trust employs around 17,000 staff.

We inspected maternity services at Leicester Royal Infirmary and at Leicester General Hospital and gathered evidence for the key questions of safe and well led at both locations. We did not gather evidence for the key questions of effective, caring, or responsive. The focused inspections were carried out to check improvements had been made since our last inspection in March 2023, after which we issued a warning notice under Section 29A of the Health and Social Care Act 2008. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

This follow up inspection was to give an up-to-date view of Leicester General Hospital acute setting maternity care since the previous inspection and help us understand what is working well to support learning and improvement at a local and national level. We did not inspect community midwifery, neonatal units, or gynaecology during this inspection because the service had not been rated as requiring making improvements in these areas. We continue to monitor the progress of improvements to services and will re-inspect them as appropriate.

Maternity

Requires Improvement 

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

- Staffing levels did not always match the planned numbers, putting the safety of women and birthing people and babies at risk.
- Staff did not always assess and identify risks to women and birthing people and act on them and did not always keep good care records.
- Action plans in response to our last inspection were in progress but not all tasks had been completed and reviewed.

However:

- Staff had training in key skills, and generally understood how to protect women and birthing people from abuse.
- Action had been taken to improve maintenance and use of facilities and equipment to keep people safe.
- Discrepancies in guidance for surgical staff had been addressed and all staff followed the same guidance.
- Medicines management had improved to ensure women and babies received their medicines as prescribed and the risk of errors was reduced.
- The service generally controlled infection risk.
- The new leadership team had become embedded and there were clear lines of responsibility with a shared vison.
- Actions had been implemented to improve the monitoring and oversight of the service to reduce risks and improve the quality of care provided to women and birthing people.
- In response to our concerns the leadership team were working with staff and an external agency to implement an improvement and monitor compliance.
- 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.
- Staff felt more respected, supported, and valued.
- Building works had begun to provide a second fully functioning obstetrics theatre, improving access to the service.

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training.

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

Most staff received and kept up-to-date with their mandatory training. As part of the PIR, UHL shared education and training data. Information for January 2023 reported Obstetrician and Gynaecology medical staff achieved a compliance rate of 97.53%, while Nursing and Midwifery staff achieved. This was above the trust target of 95% for training. Skills

drills training compliance ranged between 96-100% for medical staff across the whole service and between 73-100% for midwives and maternity support workers. An action plan was devised and shared to ensure training achieves 90% compliance. Fetal Monitoring training compliance ranged between 80-100%, with an action plan submitted to achieve 90% compliance.. This was not available at the previous inspection. Most staff were up to date with their mandatory multi-disciplinary PROMPT (Practical Obstetric Multi-Professional Training) skills and drills (which was part of the saving babies lives training day), and neonatal life support was reported as 100% for clinical staff and 91% for nurses and midwives. The service had plans in place to improve the rate for nursing and midwives to achieve the trust's target of 95%. Mandatory training included 'Recognition of the Deteriorating Women, birthing persons' which included guidance on exposure and the removal of drains.

Obstetric training compliance data equality services was 97% on average, above the service's targets. This had improved from last inspection. Training compliance with PROMPT/skills and drills which was part of the saving babies lives training day) and neonatal life support had been completed in response to last inspection across both sites in December 2023. We saw key training for equality and diversity average compliance was 98% overall. We saw training for resuscitation basic life support was 100%. Overall training for infection and prevention was just below service target at 91%. However, the leadership had identified only between 74% and 79% of nursing and clinical staff on Ward 30 had completed infection and control training and was taking action to ensure more staff undertook training.

The service's action plan reported measures to have 90% or more neonatal nurses to have had basic neonatal life support training by 29 February 2024. Leaders told us midwives also had the opportunity to attend the neonatal life support (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. In January 2024, the service reported that not all the maternity service staff had completed their mandatory sepsis training, rating it below the 90% target required. The services training data showed that at January 2024,90% of maternity multidisciplinary staff had completed the Growth Assessment Protocol (GAP and Grow) which was in line with the service's target. Medical staff received and kept up to date with their mandatory training in most areas. Improvement was required in infection and prevention control. The service provided an action plan for doctors to achieve 90% compliance which included attendance at a foetal monitoring study day and to have completed and passed a competence assessment in foetal monitoring by 29 February 2024. Compliance with PROMPT/skills and drills and 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.

The mandatory training was comprehensive and met the needs of women and staff. The service provided "enhanced maternity care" study days for 6 midwives, as a multidisciplinary training program. The service also provided an annual training day for midwives, nursery nurses, maternity care assistants, and maternity support workers covering essential job role training.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders reminded staff to complete training at local team meetings. Maternity services were supported by an education team to improve training and development across all areas within maternity. Leaders evidenced that skills and drills had been carried out at both sites in December 2023 in response to the S29a warning notice we issued after the previous inspection. The service's training figures reported were discussed at board meetings, and whilst the maternity incentive scheme (MIS) national target for mandatory training was set at 90%, the service was working towards an enhanced compliance rate of 95%.

Maternity

Safeguarding

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

All staff training compliance was 96% for adults and children safeguarding levels 1 and 2. This was above the service target of 90%. However, the safeguarding adults' level 3 was below the target at 86 %. The service was working toward improvement and enhancing staff training, but at times this had been affected by the training breakdown of compliance '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. Some areas of training had improved since last inspection. Medical staff received training specific to their role on how to recognise and report abuse.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. We spoke to staff at all grades during the inspection, and they were knowledgeable about how to report a safeguarding concern and were able to give examples of abuse. Leaders and staff understood the demographic area and diversity of women with high risks and had a clear understanding of high-risk women admitted to maternity services. For example, staff risk assessed women from Black, Asian, and Minority Ethnic backgrounds who are known to be at greater risk of experiencing poor outcomes and made appropriate arrangements. We saw a risk assessment and escalation policy in place and staff and leaders understood the risks within the local population.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to access an 'app' to see policies across maternity services. Maternity services were supported by the team and lead safeguarding midwife for all locations. This team was further enhanced following the last inspection to strengthen safeguarding supervision for staff and was working towards improving safeguarding. The team had an understanding of the risks, exploitation, and domestic abuse and actions to safeguard women and babies. Staff were able to demonstrate and give examples of safeguarding concerns for adults and children. There was a Named Midwife for Safeguarding who led a specialist team dedicated to identifying and supporting vulnerable women. This included women vulnerable to substance misuse and mental health issues. At the time of the inspection, there was a vacancy within the team for a teenage pregnancy and complex needs specialist midwife. The service notified us after the inspection this post had since been recruited to.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The staff were knowledgeable about reporting concerns for safeguarding and were supported by a designated lead across maternity services. The safeguarding lead visited wards to support staff when needed. The safeguarding lead was appointed following the last inspection to develop areas of safeguarding and supervision. Staff were able to refer to the safeguarding leads and understood the importance of this to keep women and babies safe. The staff were able seek advice from the Lead Midwife for safeguarding if they had any concerns. Staff had access to a procedure in place for high-risk cases advising processes to follow. We saw details of the trust's safeguarding guidance for staff displayed in the service.

Staff followed safe procedures for children visiting the ward. The staff used safe processes for entering all areas and used a swipe card. All areas could be monitored and overseen from staff work stations. We observed staff communicate appropriately with other professionals, women, birthing people, and visitors on antenatal and postnatal wards.

Staff followed the baby abduction policy and undertook baby abduction drills. Since our last inspection the service had established a baby abduction policy and staff undertook baby abduction drills training in December 2023 across all sites. Since our last inspection a baby tagging system had been put in place.

Maternity

Cleanliness, infection control and hygiene

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

The service generally controlled infection risk. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They generally kept equipment and the premises visibly clean.

The service generally performed well for cleanliness. Data for the period August 2023 to December 2023 showed that the service managed infection prevention and control well. Compliance in all areas against good practice was above the trust's target of 90%. Audit data had been reviewed and leaders identified where further improvements to reduce the risk of infection could be made. These included plans to support staff to complete infection control training and new monthly environmental checklists to be completed by matrons.

Maternity service areas were clean and had suitable furnishings which were clean and dust free. Since our last inspection the service had introduced disposable curtains and had a system to replace them every six months or earlier if they were damaged or soiled. All the curtains we checked were within date.

The service had taken action to address our concerns about damage to furnishings and surfaces. During our visit we saw staff checking and repairing fittings to ensure surfaces were impervious and reduce the risk of infection. All surfaces and flooring appeared in good condition.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand gel, face masks, gloves and aprons were available. Staff followed the bare below the elbow policy, were wearing face masks and were observed performing hand hygiene.

There were dedicated rooms for women and babies with infections or at risk from infection. These rooms were clearly signposted with instructions for staff on how to reduce the spread of infection and suitable PPE in the rooms. There were dedicated cleaning schedules for the management of infection in these rooms.

The Trust' hand hygiene audits for December 2023 showed compliance with good practice ranged between 92% and 100%. Data showed average compliance had increased each month since July 2023.

Staff cleaned equipment after contact with women and birthing people. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Used equipment and furniture were cleaned after each person's use and staff used 'I am clean' stickers to show that equipment and furniture had been cleaned and was ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Since our last inspection the service had taken action to improve its environment's compliance against national guidelines. Access to the unit was now restricted by electronically locked doors and staff consistently checked the identity of callers to make sure they were authorised to enter and reduce the risk of abduction or harm.

Maternity

The building of a second fully functioning obstetrics theatre was due to begin in February 2024 allowing a procedure room currently used as a second theatre to be phased out. This would enable the service to introduce separate emergency obstetric and elective caesarean sections pathways and reduce the risk of delays to elective caesarean sections. Staff told us they had been involved in the design of the new theatre and felt their views about a suitable design were taken onboard by the leadership.

The service had taken action to reduce the number of unanswered calls. Leaders had introduced a process to 'ringfence' a member of staff to answer telephone calls to the service. Being ringfenced meant the member of staff could not be diverted to undertake other duties while operating the telephone system. This reduced the risk of calls from people who were anxious or seeking guidance about a pregnancy or antenatal care going unanswered.

The service had introduced a process to check that legionella prevention measures, such as the regular flushing of all taps, were undertaken in line with best practice. Results of a flushing report for November 2023 showed that the frequency of flushings had improved. Data submitted by the trust showed that both the Delivery Suit and Labour Ward were 90% compliant and the Antenatal Unit was 70% compliant but below target. The trust and external contractor had actions in place to improve compliance.

After our last inspection, managers had requested Health and Safety and clinical teams to perform full risk ligature assessments of all maternity areas. Action had been taken which identified risk assessed ligature points in the environment. We saw ligature risk assessments were in place around the service.

Staff had started to carry out daily safety checks of specialist equipment in the Maternity Assessment Unit (MAU). We looked at 4 daily maintenance check lists for equipment and all were up to date and fully completed. Since our last inspection, action had been taken to ensure equipment was not stored in fire routes. All routes were clear, allowing unobstructed evacuation during an emergency.

Leaders had taken action to ensure emergency equipment such as resuscitation trolleys were appropriately stocked and checked against daily contents check list. We saw 2 trolleys were readily available and contained the correct equipment and medicines required during a life threatening emergency.

At our last inspection 4 of the 8 rooms in the Delivery Suite were out of service while building work was undertaken to address a national safety alert about Entonox gas levels. Entonox is a pain relief gas which women can inhale while giving birth. We saw that this work was now completed, and all 8 suits were available. This reduced the risk of women being unable to access the service when required.

The service had enough suitable equipment to help them to safely care for women and babies. Staff were able to access equipment when needed. The service had ongoing plans as per their ongoing drive to improve maternity services. The Director of Midwifery informed us that additional equipment was on order for delivery suites and across maternity to improve facilities further.

Staff disposed of clinical waste safely in line with trust policies.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Maternity

Since the last inspection, the service had implemented a telephone triage system and the service now used a nationally recognised tool to identify women and birthing people who were at risk of deterioration. Staff used the nationally recognised Modified Early Obstetric Warning Score (MEOWS) to identify deterioration in the health of women. Staff used an electronic system to document and score MEOWS. However during our inspection we reviewed the records of 2 patients which evidenced that staff had not identified they were at risk of deteriorating. We highlighted this to staff who took appropriate action to reduce the risk of these patients experiencing any harm.

The service had completed a sample audit of 150 sets of records between July 2023 and December 2023, and showed leaders staff had correctly completed the records.

Staff were able access appropriate protocols and policies. The service told us they were working towards a communications campaign to ensure care record information was always transferred to the service's electronic system. Leaders said that since the last inspection, a service wide electronic process Situation, Background, Assessment and Risk (SBAR) Alert system had been implemented on 8 January 2024. This process alerted staff if a 'reg flag' parameter was met, e.g. maternal heart rate over 140bpm, and notified the responsible midwife in charge. This enabled staff to promptly review a patient's condition and take further action if required. This supported the early detection of sepsis and the provision of additional staff to review the women and birthing persons.

Staff completed risk assessments for each woman on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff understood how to complete individual risk assessments on all women including risk assessing for sepsis and identify emerging risks using the risk assessment tools.

Since the last inspection, the service had created a specific telephone triage service whereby dedicated staff had a base separate from other areas. We saw and staff told us that the telephone triage process had made significant positive improvements to the flow of triage, the safety of women and also for staff wellbeing. Leaders provided evidence of continuous monitoring of timescales in answering the triage telephone calls giving assurance that telephone calls were being answered and managed appropriately. Triage used an electronic notes system that recorded all previous calls and relevant safeguarding information and recorded the risks of women being triaged. Calls were flagged and staff were able see if there were any safeguarding concerns or alerts. Staff reported this area had improved and was fully staffed.

Staff used a risk assessment tool based on the 'Birmingham Symptom Specific Obstetric Triage Score' (BSOTS) for maternity triage. The service had made significant improvements to the triage process and dedicated staff were allocated to triage and protected from being diverted to other tasks. We saw staff using the service's BSOTS proforma as a prompt to help them with the assessment process. Women and pregnant people attending triage/MAU for emergency assessment were seen within the appropriate timeframe The leadership team recognised that waiting times for doctors were longer out of hours and there was ongoing work to address the level of medical cover during these hours. The service continued to monitor and review the arrival and assessment times to identify areas for improvement.

Staff knew about and dealt with any specific risk issues. A Sepsis Screening Tool was updated from last inspection which included Maternity Early Obstetric Warning Score (MEOWS). The service had produced an updated, approved caesarean section guideline since the last inspection, which now included detailed guidance on the removal of surgical drains. Since the last inspection, the service had established a policy for babies who are not medically fit for discharge and who are to be adopted or fostered. The service could evidence an in-date and approved Standard Operating Procedure titled 'Unaccompanied Babies in the Maternity Unit'. This was designed to provide comprehensive care and support for babies who were without a legal guardian in the maternity unit. This protocol was designed to address situations where babies were left unaccompanied due to various circumstances, such as a mother requiring medical attention in a separate area or concerns for the baby's safety pending court decisions or local authority arrangements.

Maternity

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff completed risk assessments for women and birthing people on arrival, and we saw improvements during inspection that this was done consistently and reliably using a recognised tool. We observed detailed ligature risk assessments accessible to staff and leaders said that Health and Safety Services had assessed maternity services and updated relevant risk assessments in June 2023. This was shared by managers to the local teams, and they raised staff awareness through their local meetings.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. We discussed concerns with induction of labour with leaders. The service had taken actions to keep women safe including the use of an induction of labour (IOL) pathway. Risk with IOL were reported to the trust board and plans were in place to reduce known risks.

Staff told us that in September 2023, leaders re-established the IOL working group to agree immediate risk mitigations for the pathway and medium-term priorities to ensure the pathway was fit for the future. The service had recruited 2 additional dedicated IOL midwives to facilitate flow and enhanced care for women. A SOP (Standard Operating Procedure) for 'Escalation Process for Women Experiencing Delays in Induction of Labour' had been implemented in November 2023 which included a 'pop up' Day Assessment Unit. This unit was set up within another women's' clinic and was activated when there were any delayed inductions that require an assessment. It was a six-day service operating in daytime hours. It admitted the women newly in induction and also assessed ongoing inductions, including antenatal checks, plans of care, answering concerns and queries. It then remained the point of contact for any queries or concerns from the point of booking the induction.

Processes had been introduced so that women were likely to see or have access to the same midwife throughout their induction and have a clear point of contact. This was to improve both safety and people's experience in case of delayed inductions. An IOL 'app' had also been developed which was to provide regular performance data. This was due to be launched on 5 February 2024. This had been developed with regional colleagues and an evaluation of the impact was planned. The 'app' worked by assessing the woman's clinical risk, considering the pregnancy history and current condition, including pre-eclampsia, post maturity. This enabled women's care to have an individual care pathway, best suited to meet their specific needs. When risks were identified the 'app' escalated the case to the clinical team and the severity of the risk. Training had already commenced amongst the multidisciplinary team (MDT) that were to be responsible.

The service had developed a number of specialised clinics to support women who were at risk of experiencing health inequalities or specific conditions relating to their heritage. It is nationally recognised that inequalities in health can impact maternity outcomes, as can other contributory factors including demographic, socio-economic information, pregnancy complications, screening, engagement with service and the need to use interpretation services. The service had established the Iris Clinic for Female Genital Mutilation (FGM) and Haemolytic Clinic for conditions like sickle cell and thalassaemia. Additionally, there were other specialist clinics for the general population including a Diabetic Clinic.

Perinatal Mental Health Clinic and Maternal Medicine Clinic. Leaders recognised the challenge of having sufficient obstetric consultants in the service in order to run independent clinics for women with Type 1&2 diabetes and additional staff had been assigned to the clinic. This had reduced the number of admissions to the neonatal unit.

Maternity

Nurse staffing

Staffing levels did not always match the planned numbers putting the safety of women, birthing people, and babies at risk. However, managers mitigated risk appropriately and the service had appointed a recruitment and retention lead. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. However, after our inspection leaders told us 1:1 care in labour had since been achieved. On the first day of our inspection only 3 of the 4 planned midwives' roles were filled. Although there were contingence plans in place for community midwives to support staff on the wards, staff said they were often reluctant to approach them for support as they were traditionally known to be busy. Leaders acknowledged the service was understaffed and we saw discussions between coordinators to deploy staff to maintain safe staffing levels across the maternity service.

The service leaders had commenced a detailed and ongoing recruitment programme, working with the national challenges of midwife vacancies. The total UHL Midwifery vacancy rate for December was 9.7% with January 2024 at 8.5%. Sickness rate was improving at 8% and turnover 3.79%. Acuity tool had identified that the staffing levels for the three months prior to our inspection showed the service was on average 3.5 midwives short of desired. We noticed this was improving as new staff were being employed. The leadership prioritised the filling vacant shifts and staff absences. The service reported significant midwifery safe staffing shortages in each month from April 2023 to November 2023. We saw this trend had been reducing and the service had achieved its planned number of midwives in December 2023.

Leaders and staff told us that unexpected absence and unfilled shifts were the reasons behind the short staffing levels and that this had increased over the previous 6 months. Staff shortages had been reported as red flags in delays in time critical activity or delays in inductions of labours.

Senior leaders continued to recruit into substantive staffing posts, working to maintain relationships and visibility with student midwives. A number of midwives had been recruited to labour ward co-ordinator roles to ensure there was a minimum of two on each shift.

From January 2023 the service had recruited 57 new midwives across both sites who were in the process of joining. To increase staffing levels, service leaders offered flexible working arrangements for new recruits. Leaders told us they were waiting for a further 15 midwives to join maternity services in Spring 2024. The service was fully staffed with midwifery support workers across maternity services. Some staff worked across wards and units to cover sickness and absences.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders told us that the staffing establishment was funded in line with a national acuity tool. Staff used the tool to plan staffing levels and monitor the impact of when staff had been moved. The service used a safe staffing and escalation policy which was incorporated into the twice daily senior leadership "tactical" meetings to safely manage the service. Leaders told us they had recruited registered nurses to work within maternity to support the staffing numbers, however, the service could not always provide assurance that the workforce had the right staff, with the right skills in the right place at the right time. The service was working towards improving the skill mix of staff on each shift.

Managers could adjust staffing levels daily according to the needs of women. A joint meeting took place twice a day. The frequency of these meetings increased as necessary in response to daily pressures on the service. The meeting included reviewing staffing levels, calculated according to the number of women and patient flow. Leaders said they could adjust staffing levels daily according to the needs of women.

The number of actual midwives and healthcare assistants did not always match the planned numbers. Staff told us that whilst the inspection was ongoing the service was well staffed, but this was not always the case. Staff said they were regularly moved around the service as areas were often understaffed. Maternity services nationally were challenged with short staffing. To maintain safety, the service had employed nurses to work on maternity wards to support midwifes. Senior midwifes and leaders were also deployed to work clinically as part of the staffing numbers to cover sickness and absences.

The service had reducing vacancy rates. Vacancy rates for midwives had fallen from 14% in January 2023 to 9% in December 2023 was at 9%. This was expected to reduce further as additional midwives were planned to start Spring 2024. Managers used bank and agency staff to maintain safe staffing levels. A rapid induction package was in place.

Medical staffing

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

The service had enough medical staff to keep women, birthing people and babies safe. The service told us they had recruited an additional 9 specialty doctors to Maternity Assessment Unit (MAU) with the aim of increasing out of hours cover in obstetrics and gynaecology, to improve waiting times. In the interim, they had mitigated this risk by putting junior doctor cover shifts out to locum cover.

The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service had enough medical staff to keep women and babies safe. A consultant was available on weekends until 5pm and on call at all other times for emergencies.

The service had low vacancy, turnover and sickness rates for medical staff. The turnover of medical staff was low, and the maternity service had no vacancies for medical staff.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Records

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

Women's and birthing people's notes were comprehensive, and all staff could access them easily. However, the service continued to use a combination of electronic and paper notes which risked clinical information being missed or not being available readily available during a clinical incident. Risk assessments such as VTE (venous thromboembolism), MEOWS and handover information was accessible to staff.

The triage team had a separate electronic women's' record system. This system also held information safeguarding concerns. Leaders and staff told us that they used a Red, Amber, Green (RAG) status report to indicate how well an audit or project was doing using this series of traffic lights. The RAG rating assessment for triage/MAU was completed on a paper proforma and midwives and doctors wrote on this. Notes were paper based.

Maternity

When women transferred to a new team, there were some delays in staff accessing their records. When women were discharged back home from the wards, there were some delays in staff accessing their records as a number of women were awaiting discharge. This was often delayed due to a lack of midwives. Leaders deployed staff to reduce and manage risk by using registered nurses working across maternity. Band 7 coordinators worked across service to fill the gaps caused by sickness and absences.

Processes introduced after our last inspection had ensured to records were stored securely and kept locked. Computers were locked with a password. White boards that contained people's details were displayed in hidden areas for staff only and protected patient confidentiality.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We saw staff administer medicines across areas in line with trust procedures. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The staff were supported by a pharmacy team. There were some delays reported due to delayed discharges caused by staffing levels, however, the leaders managed this on a day-to-day basis to meet the needs of women.

Staff completed medicines records. The service used an electronic prescribing system.

Staff stored and managed all medicines safely. Medicines were stored securely, including controlled drugs, and emergency medicines had been put away after use. Systems introduced after our last inspection had been effective, ensuring medicines and baby milk was within date.

Leaders had taken action to ensure temperature checks for the medicine cupboard were completed. We looked at 2 medicine storage rooms and the temperatures of both had been regularly recorded and showed medicines were stored within acceptable temperature limits.

Staff received information on safety alerts and incidents to improve practice. Staff told us safety coordinators sent weekly emails with information on learning and that they received feedback from incidents.

Incidents

The service mostly managed safety incidents well. Staff recognised and mostly reported incidents and near misses, but some said they didn't always have time to report them. Managers investigated incidents and shared lessons learned with the whole team and the wider service and knew where improvements were needed. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them in line with service policies and procedures. Although the number of incidents being reported was increasing, some staff felt they did not always have time to report incidents. Leaders and staff knew the importance of raising an incident and supporting staff to do so.

Maternity

Managers shared learning about never events with their staff and across the trust. Managers shared learning with their staff about never events that happened elsewhere. Managers and leaders shared learning from incidents at the local meetings, bulletins and one-to-one conversations.

Staff reported serious incidents clearly and in line with trust policy. The quality improvement team led an open-door policy following the previous inspection where staff could learn and ask questions to improve. Staff said they were confident to raise and felt they would be taken seriously.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff understood the importance of openness and said that they don't get things right, but it was important to take learning from their mistakes to improve care for women and babies.

Staff received feedback from investigation of incidents, both internal and external to the service. The Trust shared information from incidents with national initiatives to improve maternity services nationally. These included, "Saving Babies' Lives" to reduce the number of stillbirths and early neonatal deaths and, 'The National Perinatal Mortality Review Tool' to support objective, robust and standardised reviews of deaths of babies. Leaders told us they reported relevant deaths to the Maternity and Newborn Safety Investigations (MNSI) programme for review and check if families would consent to be contacted by the MNSI team.

Women from minority ethnic groups experienced additional risks compared to white women that, without the right interventions, could lead to poor outcomes. Ethnicity, deprivation, and vulnerabilities information was being collated by the service to help identify how to reduce the risk to women and babies from these groups.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service and knew where improvement were needed. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership structure had changed since our last inspection A new Director of Midwifery (DoM) commenced January 2023. Two Heads of Midwifery were in post from April 2023 and a deputy Head of Midwifery in post September 2023. After our inspection the service told us a further deputy Head of Midwifery was recruited in March 2024. To support operationally, leaders had strengthened senior roles including operational leadership roles and the quality and improvement function. The service had increased the number of operational managers. Leaders knew it was important to have the right skills and experienced people in place for better quality and safety of the care and treatment being provided. Staff said this was an ongoing improvement across maternity and neonatal services. The newly appointed structure was equipped to improve services. We spoke to 10 service leaders including the Head of Midwifery, matrons, and project consultants. All reported improvements and demonstrated that work was ongoing with implementing action plans and monitoring across maternity services.

Maternity

Since the last inspection, leaders across maternity services had improved the operational and clinical governance of both structures and pathways. Leaders were assured with the progress in the reporting and escalation structures. Leaders understood their roles, responsibilities, and accountabilities. Leaders were open and honest with their progress and the improvements still required. Leaders were supported by an experienced and dedicated team across maternity and neonatal services implemented in September 2023. Leaders reported improvements to triage, induction to labour (IOL) and infection, prevention, and control processes across maternity. During the inspection, we identified some continued delays to IOL processes which leaders had plans in place to improve.

Leaders understood the demographic area of the local community and the risks of the diverse local population. Leaders said there was still work to be done working towards making sustained improvements and they had a clear understanding of the risks and challenges faced by the service. Leaders were aware of concerns raised at our last inspection and were committed to implementing the Trust's action plan to improve the service.

Staff spoke positively about the Director of Midwifery and Chief Nurse during the inspection with their increased visibility across maternity and neonatal services. However, some staff felt historical issues had not always been dealt with and were still ongoing. We spoke to leaders about the work that was ongoing to transform the service's work along with 'People Partners' human resource leaders and a 'Guardian Service' which supported staff to speak up. There was a 'empowering Voices' campaign at the service which supported staff to express cultural and operational issues they felt needed addressing. We were assured there was ongoing work with all services across maternity and leaders openly discussed how they were planning to improve support for all staff and women. During our visit, FTSUR visited staff areas to promote their role and accessibility.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust had developed the vision and strategy in consultation with staff. The strategy identified key priorities which included: listening to women and birthing people to provide personalised care, retaining and supporting staff, culture, leadership and improving compliance with national maternity safety initiatives such as the Clinical Negligence Scheme for Trusts (CNST) and the Saving Babies Lives care bundle. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports. The Ockenden reports were produced after an independent enquiry into failing NHS maternity services. They identify risks to women and actions required to ensure maternity services are safe.

The trust's action plan in response to concerns from our last inspection was reflected in the service's vision and strategy and performance was monitored by an external consultant.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff told us they felt the culture within the service was generally positive and had improved following the previous inspection. Staff told us they acknowledged that cultural change remained an ongoing issue for the service whilst

working through an improvement process. Staff felt they could raise cultural concerns with senior leaders, and they would be acted upon without fear of reprisal. Staff said that they had felt supported by the Director of Midwifery when raising issues and felt they were listened to. Staff felt included in designing the plans and care processes for the new second theatre building. Leaders continued to use the empowering voices processes due to long-standing cultural concerns.

Senior leaders were fully sighted of cultural issues and told us that progress was being made. Leaders told us the service's cultural issues were on the maternity services risk register as a priority. Leaders were fully aware of the risks posed demographically to meet the needs of women and babies. The service employed a diverse team to meet the demographic areas of women and was working towards a comprehensive understanding of the cultural needs of the local demographic area. Staff said that the culture and overall maternity services improvements were moving in the right direction and service felt better from the last inspection. We saw appropriate interactions between staff and leaders.

Leaders had changed how they listened to staff and created an independent freedom to speak up team. The freedom to speak up staff told us the service had ongoing plans to change the culture and develop a better working environment for staff. We saw a diverse workforce across all maternity services and positive interactions between staff, women and visitors. They supported the diversity of languages spoken and understanding the specific needs of the various ethnic populations in Leicestershire.

Governance

Leaders were improving the effectiveness of governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders were improving the effectiveness of systems and processes, including updating the service's guidance, policies and processes since the previous inspection in March 2023. However, some were still a work in progress and to manage risk, leaders had prioritised actions to reduce delays in discharges, and staffing levels to prevent perinatal deaths. Leaders and staff understood risks of the service. The women's governance board reported to the maternity assurance committee to ensure actions and performance complied with and supported the trust's overall objectives.

The service was represented at the board level to drive change, and this had improved from last inspection. Leaders said there was a more inclusive teamworking culture, however, more work was required to embed accountability across all areas and staff grades. Leaders said they were more supported to drive improvements with the support of dedicated action plans and monitoring. Leaders actively monitored data and performance and transferred learning into actions.

Women's governance board meetings were held monthly. It was not always site specific, it did not always monitor data specific to each location. Data was often amalgamated, which made it difficult to identify risks specific to each site or how well each site was performing. It was not always clear from meeting minutes who the chair was, and although there was representation from a consultant obstetrician and neonatologist, there was no anaesthetic representation. Service Board members and the public were informed in January 2023 that there would be a declaration of noncompliance to NHS Resolution, with only 2 of 10 recommended safety actions met. NHS Resolution is an arm's-length body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care. Progress had been made with compliance in a further 2 safety actions. Actions for all standards with partial compliance were in progress.

Maternity

After our inspection we were notified the service had submitted a 10/10 full compliance report to the NHS Maternity Incentive Scheme (MIS). MIS is a financial incentive program designed to enhance maternity safety within NHS Trusts This was subsequently submitted and has been externally verified and approved by NHSR.

Since our last inspection the service had established an 'Escalation process for women experiencing delays in Induction of Labour' process. This promoted women to see or have access to the same midwife throughout their induction when possible and provide a dedicated point of contact. This improved both safety and people's experience in case of delayed inductions.

Leaders escalated concerns at trust board level to maintain the safety of women and babies across maternity and neonatal services. We saw appropriate policies across the services and staff said they were kept informed through meetings, huddles, and daily multidisciplinary meetings of any changes across maternity services. Sine our last inspection the service had taken action to review polices and ensure they were up to date.

The service leaders reported to the trust board in the "mortality and learning from deaths quarterly report". The December 2023 report showed evidence of learning from deaths and the sharing of maternity quality monitoring information with external research agencies such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, (MBRRACE-UK). MBRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths, this allowed the service to influence national maternity improvements and be open to scrutiny from external sources. Leaders reported the stillbirth rate had fallen below the national average of 3.9 to 3.86 per 1000 births in 2022. The stillbirth rate was now comparable to the peer group rate. However the neonatal mortality rate continued to be more than 5% higher than the mean rate for the peer group (both including and excluding congenital anomaly).

UHL did not have any intrapartum stillbirths reported to MBRRACE-UK in 2022 but a higher rate of neonatal deaths due to fetal conditions compared to the national average (8.8% vs 3.9%). These are conditions which have a very high mortality rate (commonly fetal hydrops or cardiac arrhythmias). The service took referrals from a wide geographical area.

Further peer review of cases was being scheduled with other stakeholders to establish a learning consortium with large perinatal centres with associated cardiac and surgical services. The service was working with NHS England Midlands Public Health colleagues as part of joint work to further understand the wider determinant of health. Actions were taken to improve the service and wider maternity care such as reviewing population groups to identify health inequalities and working with dedicated networks. The report also showed that "the quarterly number of stillbirths in 2023 was similar to the pre-COVID pandemic year and that there were fewer neonatal deaths in quarter 2 of 2023/2024 (financial year) than previous two quarters". The report included 29 perinatal deaths that had been reviewed. The issues, actions and learning from deaths are report to the Quality Committee.

We reviewed the service's perinatal mortality review tool (PMRT) summary report for the period March 2023 to February 2024 and found that 83 cases were open for review. 18 PMRT reviews had been completed with 64 remaining in progress. The PMRT report showed the bereavement team were involved in 5 of the case reviews and risk manager or governance team in 13 of the cases. The service was focused on improving the turnaround of these cases such as the recruitment of a dedicated PMRT lead midwife. A member of the risk /governance team, Safety Champions and obstetricians attended the reviews. We were not fully assured by the service's governance processes, and systems. PMRT and reports provided by the service told us there were missed opportunities to highlight actions and learn lessons following all babies who had died.

Maternity

Although action had been taken to improve the service's governance processes and systems, further action was still required. PMRT and reports provided by the service told us that there was a lack of actions and lessons learned following the death of every baby. The service was asked to provide copies of referrals to the Maternity and Newborn Safety Investigations team (MNSI) for babies that had died. The MNSI is part of a national strategy to improve maternity safety across the NHS in England.

The service was not consistent in its reporting. The trust initially told us there had been no baby deaths reported to MNSI since the March 2023 inspection. However, after the inspection, the service provided details of 4 cases that had been referred for investigation.

Service leaders were focused improving the governance regarding PMRT and an additional PMRT Midwife commenced in January to support the process. The service reported all families were given the opportunity to offer input into the PMRT review and ask questions. Leaders recognises that the majority of families were choosing not to take part in the review. After our inspection Leaders reported that engagement had significantly increased since the appointment of a PMRT Specialist Midwife.. Managers had planned a comprehensive programme of audits to identify gaps and to monitor change and drive improvement. However, leaders said that this was impacted by the ongoing staff shortages.

The last inspection identified a general lack of oversight and monitoring of systems and processes throughout the maternity service and that managers were not always aware of risks, the level of risk and which meant it was difficult to prioritise improvements and to implement change. We found that senior leaders had a defined an improvement plan that identified priorities and were fully committed to making the required improvements.

Leaders disseminated learning by bulletins and threaded learning for mandatory training. We saw governance boards, and infographics available for staff and patients. Due to the ongoing staffing issues, clinical midwives were not always able to attend learning forums which put them at risk of not being aware of current issues and their role in implementing improvements.

Management of risk, issues and performance

Leaders and teams used systems to aim to manage performance effectively and leaders had recognised where improvements were needed. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. They had plans to cope with unexpected events. Staff contributed to decision-making to at local level meetings and quality improvement meetings.

We noted many improvements since our last inspection although further improvement initiatives required completion. Leaders were aware of the risks within the service and had plans in place to mitigate risk and improve performance. Risk registers generally reflected risks within the service and priorities were reflected in improvement plans. Risks we found on inspection had been recognised by senior leaders. Leaders said a detailed risk assessment tool was completed on the patient's arrival and admission and was reviewed regularly, including after any incident. Leaders recognised the need of further improvements as staff did not always report incidents due low staffing and lack of time to complete incident reporting.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service analysed data and had the oversight to improve information sharing across local teams. All areas displayed a performance dashboard showing performance and risk information across the maternity services. This was accessible to all people, and staff were informed of changes and were involved in making changes. Since the last inspection, the service had made improvements for staff and leaders to come together via a quality improvement meeting to influence change and improvements. The service submitted the required data returns to all relevant national programmes as required. During our inspection we saw staff from the IT department conducting a weekly check of the computer operating systems in the service. This ensured that any risks to the accurate collection and distribution of monitoring information and women's and babies records would be identified promptly.

Engagement

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

We noted there had been a fresh focus on the 'Empowering Voices' agenda, as the service had re-engaged with the Maternity and Neonatal Voices Partnership. The MVP is an external organisation which listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.

We saw positive staff engagement with women and families visiting the service. The workforce was diverse to meet the needs of the local population. Leaders had enhanced communication processes with all staff to capture their experiences better to drive improvements. All the women and their families we spoke with said they had regular contact with staff and were supported to take a proactive approach in their care and birth plans.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

After our last inspection the leadership structures had been recognised to enable a more effective staffing and governance infrastructure across maternity services focused on risk and improvement.

In November 2023, the Trust launched its Perinatal Safety Improvement Programme comprising of four workstreams to align with the National Three-Year Maternity and Neonatal Improvement Programme. Actions to address the concerns raised at our last inspection were assigned to the most relevant workstream. Assurance was provided to the Perinatal Safety Improvement Programme Group and then to the Maternity Assurance Committee. Action tracking and evidence to support sign-off was filed in a secure project management tool to accessible to all stakeholders. We were assured that the project manager and the quality improvement team was enhancing the quality of care and treatment provided. Staff were supported to engage in this process and able to see where actions had been effective and areas which required further improvement. Leaders regarded staff as important to leading change and improvement. Staff were able to attend monthly improvement briefing meetings to see where changes were made and suggest areas to review. Leaders and staff understood the challenges faced on day-to-day basis with capacity and flow. A specific project manager oversaw and supported the changes required to demonstrate compliance with the section 29A warning notice that we had issued after the last inspection.

Maternity

Outstanding practice

We found the following outstanding practice:

An Induction of Labour (IOL), app has also been rapidly developed which will provide regular performance data. This is due to be launched on 5 February 2024. This has been developed with regional colleagues and an evaluation of the impact is planned. The app works by stratifying the woman's clinical risk, considering the pregnancy history and current clinical picture, including but not limited to 2 'presence of meconium', pre-eclampsia, post maturity. As each woman progresses along the pathway, regardless of whether she has commenced clinical intervention, the application automatically updates and escalates the case to the clinical team, using red. Amber and green indicators. Training has already commenced amongst the MDT who will be responsible.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

- The trust must ensure that the use of MEOWS is consistently implemented across the service in line with the policy. Regulation 12 (2) (a)
- The trust must ensure there are always enough suitably qualified and skilled staff on duty. Regulation 18 (1)
- The trust must ensure staff report all incidents in line with the incident reporting policy. Regulation 12 (2) (b)

Action the trust SHOULD take to improve:

Maternity

- The service should consider further separation of its maternity data for all sites.

Our inspection team

On the first day the inspection team included 2 CQC inspectors and a specialist advisor with experience as a trained and experienced maternity manager. On the second day the inspection day team included a CQC inspector and 2 specialist advisors with experience and trained in maternity and theatre services. The inspection was overseen by Caroline Jenkinson deputy director of operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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