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 

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 General Hospital.

We inspected the maternity service at Leicester General Hospital 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 Royal Infirmary and St Mary's Birth Centre, run by University Hospitals Leicester NHS Trust. Our reports are here:

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

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 imporvement 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 women and birthing people and babies at risk.
- 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 and 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 well.
- 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, improve the service and ensure good oversight of this.
- 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 women and birthing people from abuse.
- The service generally controlled infection risk.
- 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, and not by location, which meant we could not be assured of the obstetric training compliance data for Leicester General Hospital. Training compliance with PROMPT/skills and drills (which was part of the saving babies lives training day) and neonatal life support (NLS) 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 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, and we could not be assured that staff unable to attend would watch recordings if protected time was not allocated for this. There was an annual week of sessions on fetal monitoring in May 2022 and 2023 which staff could attend if available or watch the recordings, however we do not know whether protected time was allocated for this. This meant we were not assured about how effective continuous training was.

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 thre 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 and 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's levels 1 and 2 and for safeguarding children level 3. We did not receive separate data for safeguarding adults' level 3. A breakdown of compliance for safeguarding Level 3 showed compliances ranging from 96 % to 100% for the different areas of the maternity service across all sites, but 89% for medical staff. It was not clear whether this included both children and adults' Level 3 safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to give examples of safeguarding issues.

Staff generally knew how to make a safeguarding referral and who to inform if they had concerns.

There was a baby abduction policy, however some staff we spoke with did not know the details of the baby abduction policy.

Cleanliness, infection control and hygiene

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.

Maternity service areas were generally clean and had suitable furnishings which were clean, but these were not always well-maintained. The areas we visited were generally visibly clean and dust free. However, curtains on wards and in shower rooms were not disposable, and curtains in the maternity assessment unit (MAU) were disposable but did not have dates marked for when they should be changed.

We noted there was damage to some furnishings, such as a table in the maternity assessment MAU, and damaged flooring and tiles in a shower room on ward 30. There was an outdated wooden pull-down chair in one of the shower areas on ward 30.

The service generally performed well for cleanliness. Overall scores for cleaning audits for delivery suite, theatre and areas outside theatre were over 97% for November 2022 to January 2023. Cleaning audits for November 2022 and December 2022 for Ward 30 showed overall scores over 98%. Cleaning audit overall scores for November 2022 and January 2023 were over 98% for MAU and a cleaning audit of antenatal clinic in November 2022 showed an overall score of 98.3%.

Staff followed infection control principles including the use of personal protective equipment (PPE), but audit data did not always demonstrate good compliance. Hand gel, gloves and aprons were available. Staff followed the bare below the elbow policy, were wearing face masks and were observed performing hand hygiene. We saw the results of hand hygiene audits for October, November and December 2022 for delivery suite and Ward 30. These showed compliance of 90% or more for these months for each area, except for delivery suite in October 2022 which had 89% compliance. We

saw the results of infection prevention audits for October, November and December 2022 for delivery suite and ward 30. In October 2022 these showed compliances of 77% and 71% for ward 30 and delivery suite respectively but were 90% or more for these areas for November and December 2022. We did not see audit data for other areas of the maternity service such as triage/MAU or antenatal clinic.

Staff cleaned equipment after contact with women and birthing people. 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 did not always keep people safe. Staff were trained to use them. Staff generally managed clinical waste well.

The design of the environment did not always follow national guidance. There was no process to monitor the number of people who visited to see women, birthing people and their babies. We observed visitors press the entry buzzer and enter without staff checking who they were, or who they were visiting. We also saw visitors tailgating. We escalated this to the Director of Midwifery who immediately carried out a risk assessment and assured us that mitigations were in place to ensure babies were safe and not at risk of abduction.

A procedure room was being used as a second obstetric theatre. Managers told us the second obstetric theatre was not fit for purpose from both an estate and staffing point of view. Staff said they would only use the second theatre if necessary, which meant both elective and emergency cases were completed in the same theatre. A business case had been approved for a new build theatre on site, to ensure a second full theatre was available. The lack of a fully functioning second theatre and theatre team meant they had not been able to separate emergency obstetric cases and elective caesarean sections which meant there were delays to elective caesarean sections. Leaders told us there was a plan to separate the emergency and elective pathways in 2023/2024.

At inspection we saw that a person attending for elective caesarean section was brought into the theatre ready for the procedure, however they then had to leave theatre due to an emergency case that needed to take priority. They were not able to return to theatre for their elective caesarean section until over an hour and a half later.

The service supplied data for delays to elective caesarean sections between November 2022 and February 2023. This showed 76 were delayed or postponed, with 5 out of 76 delays being due to an emergency taking priority. Leaders suggested that inductions of labour (IOL) could also be impacted by emergencies. Managers told us they would also like to separate IOLs, along with elective caesarean sections, from delivery suite emergency work so that IOLs were not affected by emergencies either.

Telephone triage was based in the triage/MAU staff office so was not separated from the triage service for in person attendance for assessment. This meant the telephone triage service was affected by activity within the in-person triage assessment service.

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.

Maternity

Staff did not always carry out daily safety checks of specialist equipment in MAU and we found expired equipment on the MAU and antenatal/postnatal ward.

Staff did not always carry out legionella prevention measures. Staff told us there was a flushing regime for taps in maternity areas including those not used very often, they received email reminders for this, and confirmation of flushing was logged on an electronic system. We saw the results of the compass flushing report for the period 5 December 2022 to 1 January 2023. This showed that for delivery suite 58% of flushing was on time and 42% was not done. For the MAU 83% was on time and 17% was not done. For ward 30, 67% was on time with 33% not done, and for the antenatal unit 95% was on time with 5% not done. It was noted at the Women's Infection Prevention Meeting in January 2023 that legionella testing on the delivery suite, in MAU and on ward 30 needed to be looked at.

During the inspection we noted that the Ward 30 to Ward 31 fire route was blocked. This was escalated at the inspection.

The service did not always have suitable facilities to meet the needs of women and birthing people and their families. There were no en-suite toilet facilities for women and birthing people in labour on the delivery suite, and there were only 2 shared toilets and 1 shared shower room. This meant that if women and birthing people were unable to walk to the shared facilities, they would have only the option of using bed pans.

Delivery suite had 8 rooms but at the time of inspection there was reduced capacity due to 4 rooms having work to the ventilation systems to address a national safety alert about Entonox levels. We saw risk assessments for Entonox workplace exposure limits for staff and for the inability to provide Entonox as an option for pain relief, but not for the reduced capacity as a result of this work, and how this reduced capacity was being managed and mitigated. However, leaders told us there were no incidents or complaints due to the reduced capacity, although we did not know whether there was any impact on service delivery, such as delays.'

Visiting for partners was from 9am to 9pm or on an individual case by case basis, not 24 hours per day as it was before Covid. It was not clear why 24/7 visiting had not been re-introduced for family members. There was some extended visiting, but this had to be agreed with the trust. Partners of those attending for IOL could stay 9am to 9pm unless by exception.

The service did not always have enough suitable equipment to help them to safely care for women and birthing people and babies. There was no defibrillator on triage/MAU, the nearest available defibrillator for MAU was on delivery suite. Staff knew where this was, however, there was a corridor between the 2 areas, and we were not assured the defibrillator could be accessed in a timely way due to the layout. During the factual accuracy period the service told us they were taking action to ensure there was a defibrillator for each ward.

Evidence provided by the service showed that compliance with servicing of clinical equipment, which was not broken down by site, was poor across the service 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.

There was guidance for planned maintenance of medical equipment, which was version controlled but not dated. It was not clear from this how planned maintenance was monitored, except to say that it was the responsibility of the planned maintenance lead. Information provided itemised equipment and stated the last planned maintenance date, but not when the next service was due. Therefore, we were not assured there was reliable oversight of maintenance.

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.'

Staff disposed of clinical waste safely but did not always have the most appropriate type of sharps bin. Foot operated waste bins were in working order and clinical waste bins were secured in a locked area. Sharps bins were generally labelled and used correctly.

Assessing and responding to risk

Staff did not always complete and update risk assessments and 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 deterioration in the health of women and birthing people, but we found they were not always compliant with this. Staff used an electronic system to document and score MEOWS. We requested the maternity early warning score audits for the 3 months prior to our inspection, however, we received the overall results for October, November and December 2022 for Ward 30 and the midwifery led unit only. These showed compliance rates between 71%, and 100% for Ward 30, and 75% and 100% for the midwifery led unit. 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.

Women and pregnant people attending triage/MAU for emergency assessment were not always seen by a doctor within the RAG rating time frame. This did not include the smaller group of people attending triage/MAU for day assessment or postnatal care, which did not require triage using the RAG rating assessment times. Some staff told us that on the triage assessment proforma, the 'arrival in triage' time was when the maternity care assistant (MCA) completed observations and a urine test, and the 'initial triage assessment' time was when the midwife completed the triage assessment. Some staff said 'initial triage assessment' could be either the time seen by the MCA or the midwife, and that the midwife may triage and RAG rate some people based on the MCA observations measured, the notes and presenting issue, rather than seeing them in person. Staff told us that on arrival women and pregnant people would present to the triage/MAU staff office, and there was a waiting area outside the triage rooms. There was a separate paper logbook where 'arrival time' and 'time seen by midwife' could be recorded. Therefore overall, it was not clear what time the clock started. Evidence provided as part of this inspection showed there had been zero red flags recorded for any delays between presentation and triage during the 6-month period August 2022 to January 2023.

Maternity

We saw the results of an audit of triage records across both sites from July 2021 to November 2021. This showed that out of 249 records audited 242 records had not had the BSOTS paperwork completed. Only 176 women and pregnant people had been categorised with a RAG rating, and of these only 121 had been categorised correctly. An action plan for this audit was provided with deadlines of April and May 2022. 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. The reasons for the re-launch being unsuccessful included not having the required staff.

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. The information about previous calls was not flagged, and the user would need to look specifically for this and other risk factors, however 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 covering telephone triage told us they would always try to re-contact women and pregnant people who had not attended after being advised to come into triage but said whether this happened depended on what else was happening on triage/MAU. This meant we were not 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.

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.

Staff used the 'fresh eyes' approach to fetal monitoring ('fresh eyes' is a checking system that uses peer review to give a second opinion on CTGs). However, there was inconsistency among staff completing fresh eyes. Some staff were completing fresh eyes hourly as per national guidance, but some were completing it 2 hourly based on a 2015 electronic fetal monitoring guideline which was not in line current with national guidance. We saw the results of ten monthly audits of fresh eyes compliance for January 2022 to September 2022 and for November 2022. These showed variable compliance ranging from approximately 80% to 100%. We did not receive an action plan for these audits. However, we were told spot check audits were discussed at band 7 meetings.

We saw the full results of a monthly spot check audit for January 2023 only. This reviewed 28 sets of records and found compliances of 86% for hourly assessment of the fetal heart and 61% for fresh eyes.

Staff used the Dawes Redman criteria for antenatal CTGs. We saw there were intrapartum CTG assessment stickers in place and fresh eyes assessments in the notes. We witnessed an effective fresh eyes procedure. However, doctors used the DR C BRAVADO mnemonic instead of intrapartum CTG stickers, therefore there was inconsistency in the approach to CTG interpretation and documentation between midwives and some doctors.

Maternity

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 some gaps 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 which showed that venous thromboembolism (VTE) risk had been assessed, high or low risk pregnancy was defined, and antenatal screening had been completed. However, we saw inconsistent recording of fetal growth, carbon monoxide (CO), and routine enquiry for domestic abuse.

A monthly spot check audit of notes for January 2023 showed compliance of 89% with intrapartum risk assessments and 82% with postpartum haemorrhage risk assessment.

Audit results (not broken down by site) showed compliance with risk assessments 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 were not provided with an audit of intravenous (IV) antibiotics given within 1 hour for sepsis for Leicester General Hospital.

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%.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people. We reviewed 3 sets of records and saw that mental health assessments had been completed.

Shift changes and handovers generally included necessary key information to keep women and birthing people and babies safe. However, we attended the morning medical handover on the delivery suite and were not assured this was a multidisciplinary handover as there was no anaesthetist present and there were no introductions. The handover also took place in an area behind the main staff desk, therefore was not private and we were not assured that confidentiality was always maintained.

Following handover, the medical team also discussed a list of women and pregnant people due to start an IOL, or who were already in the process of IOL. Staff told us this was an informal process where those having inductions were prioritised by the consultant in the mornings and afternoons.

We attended a further team meeting following the medical handover which was attended by obstetric, anaesthetic, neonatal and theatre staff, a midwife from MAU and the bleep holder. This meeting included discussions on staffing levels for midwifery, neonatal and medical staff, IOLs including delays, ward related information, for example the ventilation work, and details of the elective caesarean sections for the day including the check in process (antibiotics, blood products, equipment, suitability for enhanced recovery). There was also a discussion about where to get a second operating department practitioner, scrub nurse and obstetric consultant if required for a second theatre opening.

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.

IOLs were assessed twice a day with the MDT and consultant and there was a coordinator who scheduled IOLs. Staff told us the coordinator would call people the morning of their IOL to advise them when to come in depending on beds, acuity and staffing. The service did not audit IOLs, but monitored them in the daily tactical meeting and documented red flags on the birthrate plus intrapartum acuity tool, to inform site acuity levels. Staff told us there were major delays in the IOL process and that delays were greatest at the point of artificial rupture of membranes (ARM) due to lack of one-to-one care, due to staffing shortages. They told us they could have up to 7 women and pregnant people waiting for ARM.

However, staff said that delays once IOL had been started, for example at the stage of artificial rupture of membranes (ARM), were not reported as incidents, but they did report IOLs delayed more than 24 hours. This meant we were not assured the service had effective 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. There was no risk stratification in place for high risk IOLs recorded on the ward. The junior doctors covering MAU during the day did not have pagers, and the delivery suite consultant did not carry a pager, 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. However, during the factual accuracy period the service told us they were addressing the choice of individual doctors given a pager.

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 woman and birthing people and babies at risk.

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Maternity

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.

Staff told us the service had been very short staffed, which had 'been really hard work' with staff 'pushed to the brink'. They said there used to be 13-15 midwives on delivery suite, but now on some shifts there were 7-8 midwives and 2 MCAs.

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.

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 834 red flags were reported. The majority of red flags were about delays in induction of labour (IOL), with 637 red flags for delay in continuing IOL, and 13 for delay between admission for IOL and beginning of the process. For delayed or cancelled time critical activity there were 169 red flags, and for delivery suite coordinator not supernumerary there were 15. However, there were zero red flags for any occasion when 1 midwife was not able to provide continuous 1:1 care and support during established labour.

The staffing challenges meant that staff could not always take breaks during their shift due to leaving unsafe staffing levels.

Staff told us the delivery suite coordinator assessed each shift, shortfalls were known and there was a text system for staff who had opted into this for both advance and last-minute shift booking.

The service used a birth rate acuity tool which was completed 3 times per day and highlighted red flags. Staff told us intrapartum birth rate was embedded on delivery suite and there was a safe staffing matron to contact, however acuity on the antenatal/postnatal ward required review and embedding as it was not working as it should. Some staff we spoke to could not describe how this information fed into the safety/tactical meeting and staffing assessments.

Staff on triage/MAU told us they could not always attend the tactical meeting with the rest of the maternity team if they were busy on triage/MAU. Staff told us they were not provided with feedback on capacity and acuity within the service, for example some were unaware of plans for IOLs or delays in transfer to delivery suite.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of woman and birthing people.

Maternity

The service did not have a full second obstetric theatre team available when a second obstetric emergency required opening of a second theatre out of hours. An on-call operating department practitioner (ODP) for the second theatre after 10pm was based at home and would attend when called, however, managers told us this took about 30 minutes. This meant there could be a delay in delivery. Managers recognised this risk and told us the funding of an additional ODP to be on site and available was linked to the estates funding for a second theatre.

When the second theatre opened out of hours, a member of the midwifery staff would have to scrub to perform the role of scrub nurse, which is not in line with national guidance. Staff told us not all midwives were able to scrub, and those who were, had difficulty maintaining their scrub skills due to performing this role infrequently. This also removed a midwife from other areas of the service. Staff told us that often only the delivery suite coordinator was able to scrub, which meant the service was without a delivery suite coordinator if 2 theatres were open out of hours. Managers told us these risks were mitigated by women and birthing people being risk assessed for suitability to deliver at this site, with any people who were high risk going to the Leicester Royal Infirmary. We were also informed staff could get support from the general emergency theatre (only if not in use), and staff could move between the sites if needed, which they said was possible in 15 minutes.

We raised our concerns regarding the second obstetric theatre following our onsite inspection, the service produced a new standard operating procedure (SOP) for opening the second theatre within 30 minutes. They planned to complete drills to check compliance with this SOP and were going to monitor decision to delivery times. They also told us they stopped using midwives for the theatre scrub role from April 2023.'

The Birthrate Plus acuity report 2022 showed that the main 3 management actions taken when staffing did not match acuity were redeploying staff from the ward, redeploying staff from MAU and emergency SOS text sent to staff. This meant the wards and MAU were depleted to cover delivery suite.

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.

Staff said they were told about additional training days available and had opportunities to do additional training.

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

Medical staffing

Maternity

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.

During normal working hours there was 1 consultant covering delivery suite and triage/MAU, and up to an additional 2 consultants providing cover in antenatal clinic, scan room and MAU and the ward. If a second consultant was needed for a second emergency requiring opening of a second theatre, managers told us the second consultant would come from the scan list or antenatal clinic, which would be paused. Managers told us there were 3 consultant post vacancies. This meant triage/MAU did not have consultant cover for 4 hours in the afternoon from Monday to Friday, and there was not always consultant cover for 1 hour each morning for the ward round on ward 30.

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. The ward round on Ward 30 was inconsistent as there was no fixed time of day it would take place. We were told this was due to gaps in the consultant rota, which meant the delivery suite consultant often had to cover this ward as well, depending on the activity on the delivery suite. If not covered by the delivery suite consultant, staff said they would find a consultant from elsewhere, for example antenatal clinic. Staff told us that sometimes they only had a Foundation Year 1 (FY1) doctor as their junior doctor below registrar level on delivery suite, and that they were only able to work at a basic level.

Data submitted by the service together with information from staff during inspection showed that Foundation Year 1 (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.

Maternity

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 given the specialised nature of obstetrics. This is not usual practice, however, should be risk assessed and appropriate and enhanced supervision provided.

Leaders told us they acknowledged the risks presented by the state of medical staffing and had submitted a business case in November 2022 for an additional 9 specialty doctors. This had been approved and we were told they were in the process of recruiting for this.

The service always had a consultant on call during evenings and weekends. Out of hours there was a consultant obstetrician resident until 8pm and then on call from home. The on-call consultant covered delivery suite, MAU, the maternity wards and emergency department.

There were regular consultant led ward rounds, however the required professionals were not always present, and compliance was low. 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 15% to 31% for November 2022 to January 2023.

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.

Records

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

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 records.

Telephone triage notes were documented on an electronic records system. However, the triage assessment proforma was a paper form, therefore midwifery and doctor notes for this were handwritten. Staff told us doctors reviewing women and pregnant people in triage/MAU did not document their clinical judgement on the electronic notes system, which meant this would not be visible when other staff were using the electronic system. This meant triage/MAU staff needed to transfer paper notes for both midwives and doctors onto the electronic system, which duplicated work. The paper triage form would then be filed in the main paper-based records. There was a box to tick to confirm the triage paper notes had been entered onto the electronic system before being filed in the records, but this had not always been ticked. Therefore, we were not assured that paper triage assessments were always transferred to the electronic system.

GPs could not access the electronic notes system. Therefore, if a woman or pregnant person was advised to see their GP, the GP would not be able to access the telephone triage notes.

Inpatient notes were paper, and MEOWS scoring, and medicines prescribing were on an electronic system.

There service had not completed records audits, therefore could not be assured as to the quality of the records. However, managers told us there was a working party looking into auditing electronic and paper records.

Records were not always stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. However, on the postnatal ward the baby notes trolley was locked but the access code to the locked trolley was on display next to the keypad.

Medicines

The service generally used systems and processes to prescribe, administer and record medicines, but did not always safely store medicines.

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

Staff did not always store and manage all medicines safely. On the ward and triage/MAU medicines were generally stored securely including controlled drugs. However, some emergency medicines had not been put away. On triage/MAU temperature checks for the medicines cupboard were not always completed. On ward 30 temperature in the medicines and milk rooms was higher than it should be for storage, and records showed some fridge temperatures outside the recommended range. Staff told us this would be escalated to the midwife in charge on delivery suite, but not reported as an incident.

We found 1 bottle of milk in the fridge which was dated 27 February 2023.

An emergency delivery box contained a medicine that required a revised expiry date when stored at room temperature. Whilst the date the medicine was removed from the fridge had been recorded, staff were unsure of the revised expiry date. Therefore, we were not assured this medicine would be safe and effective if administered.

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 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 with staff. 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 concerns that incidents were not routinely reported. For example, delays at the ARM stage of IOL, opening a second emergency theatre overnight, and incorrect medicines room and fridge temperatures.

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.

Maternity

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. Managers investigated incidents and involved woman and birthing people and their families in these investigations. 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 about incidents. 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. There were 2 investigation reports significantly overdue, but we were told there were no care delivery issues or actions for 1 and that actions had been completed for the other.

Staff told us they understood the duty of candour, and that they were open and transparent and gave women, 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.

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 any serious incident.

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.

Maternity

The chief nurse led a review of the maternity leadership structure 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 were 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.

At the time of our inspection there were live 2 adverts, 1 for an additional matron to act as the named midwife for safeguarding: and site-specific maternity service co-ordinators to provide 24-hour cover to ensure site-based leadership and 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. They 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 was provided 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.

The chief nurse/midwife reported directly to the board since May 2022. They 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. 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, although, this was not articulated by staff during our onsite inspection.

Maternity

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.

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 we reviewed.

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 recently been recruited 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 and 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 a 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.

Staff were focused on the needs of women and birthing people receiving care and showed respect for them as individuals. However, the environment on labour ward made it difficult for them to always preserve their dignity and respect.

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

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

Maternity 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 through 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, 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 when the investigation was completed. However, we noted there had been 3 recent complaints where related notes could not be found.

Maternity

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 managers 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 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.

Maternity

An independent desktop review of the maternity services' governance systems, themes, and trends, commissioned by the local Clinical Commissioning Group in 2022, recommended the maternity services invest greater time to describe and understand the story of women and birthing people that reports related to. This would 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 NHS staff survey for 2021 (published in February 2022), 89.6% of maternity staff said they always knew what their work responsibilities were and 71.3% said they were able to make suggestions for improvement.

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 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.

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 only considered staffing numbers and not the numbers 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 had supportive practice placements.

There was one risk register for all 3 maternity locations. We found many examples of risks that were not being managed and which we had to highlight. This included risk of baby abduction on the postnatal ward, lack of oversight of acuity and risk in triage, and the risk of some medical staff not having pagers and using personal mobiles when connectivity was known to often be an issue.

We found some examples of significant risks that were known but not managed. These included the risk of elective caesarean sections being part of labour ward acuity and without a dedicated team, 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 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 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 find the data they needed, in easily accessible formats, 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 their 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 did not integrate with each other. We saw staff had difficulty navigating their way around the system, to find relevant information. Staff wrote in handheld notes and then duplicated in electronic notes, which created opportunities for error. Staff told us they did not always have time to transfer information to electronic records. 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 has not been 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 which 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 with links between maternity systems and access to necessary data.

Maternity

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.

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. However, maternity services were not using the data to plan and target services to families most in need, and 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. T The Healthcare Safety Investigation Branch attended to discuss 'Learning So Far', and a law firm attended to present on 'Achieving a Culture of Candour.'

Maternity

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 was awarded full United Nations Childrens Fund (UNICEF) baby friendly initiative accreditation in July 2019. Re accreditation had been delayed to November 2022 due to the pandemic. Some further work was required to ensure all baby friendly standards were embedded, and maternity services were continuing to work towards re-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.

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

Maternity

Action the trust MUST take to improve:

Maternity

- The service must ensure the second obstetric emergency theatre is fit for purpose and safely staffed to accommodate the most pressing emergencies (Regulation 12 (1) (2) (a) (b) (c) (d)) and regulation 18 (1) (2) (a)).
- The service must ensure the security of the unit is reviewed in line with national guidance. (Regulation 12 (1) (2) (a) (b) (d)).
- The service must ensure the fire routes are clear from any obstructions (Regulation 12 (1) (2) (a) (b) (d)).
- 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 compliance with the correct completion of early warning scores (Regulation 12 (1) (2) (a) (c))
- 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)).
- 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 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 and the second obstetric theatre are closely monitored, managed and improved (Regulation 17 (1) (2) (a) (b) (f)).

Maternity

- The service must ensure the business case for second obstetric theatre is expedited to ensure the estate and staffing of second obstetric theatre is safe and fit for purpose (Regulation 12 (1) (2) (a) (b) (c) (d) and regulation 18 (1) (2) (a)).
- The service must improve the culture and ensure staff are actively encouraged to raise concerns, report incidents, and ensure the workstreams generated from the Empowering Voices project comes to fruition (Regulation 12 (1) (2i))

Action the trust SHOULD take to improve:

The service should ensure that:

- All staff have completed safeguarding adults and children Level 3.
- All staff are familiar with the baby abduction policy.
- All staff use correctly colour coded sharps bins.
- All staff receive an annual appraisal.
- The service should scrutinise data related to ethnicity and vulnerabilities, and use it design maternity services to address inequalities.

The service should consider:

- Routine incident reporting for delays for artificial rupture of membranes and second theatre opening.
- 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.