Leeds Teaching Hospitals NHS Trust

St James's University Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at St James's University 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 St James's University Hospital.

We inspected the maternity service at St James's University 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 a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We did not review the rating of the location therefore our rating of this hospital stayed the same.

St James's University Hospital is rated Requires Improvement.

We also inspected 1 other maternity service run by Leeds Teaching Hospitals NHS Trust. Our reports are here:

- Leeds General Infirmary - https://www.cqc.org.uk/location/RR801

How we carried out the inspection

During the inspection we spoke with 25 staff including the director of midwifery, head of midwifery, obstetricians, doctors and midwives. Attended handover meetings, reviewed 6 records and spoke with 6 women and families.

We received 163 give feedback on care forms through our website of which 29 were mixed, 36 were negative and 98 were positive. Feedback received indicated women and birthing people were mostly positive about their experience on the delivery ward but did not feel supported when on the postnatal ward because there were not enough staff, delays in receiving pain relief or they did not find staff to be compassionate in their approach.

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

Maternity

Good

Maternity services at St James's University Hospital includes: antenatal, intrapartum (care during labour and delivery) and postnatal maternity care.

The maternity unit includes an obstetric consultant-led delivery suite, maternity assessment centre (triage), and wards for antenatal and postnatal care.

In the calendar year 2022 there were 4060 births at St James's University Hospital.

Maternity services were previously rated alongside gynaecology services in 2016. CQC split the assessment of maternity and gynaecology in 2018. As such the historical rating maternity services at St James's University Hospital are not comparable to the current framework used for inspecting maternity services. This means that the resulting rating for Safe and Well led from this inspection will result in an overall rating for maternity services.

We rated Maternity services as good because:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. and all staff were committed to improving services continually.

However:

- It was not clear how woman and pregnant people would be supported within the triage waiting area because this waiting areas was not in the line of sight of any staff and there was minimal information for woman about what to do should they require support. The trust took immediate action to monitor the number of patients required to wait in this unobserved waiting area and provided a portable buzzer so women and pregnant people could summon support should they need to.
- There was a lack of oversight of calls coming into triage, this meant leaders did not know how long women and pregnant people were waiting to get through on the telephone or the rate of call abandonment.

Is the service safe?

Good

We rated safe as good.

Maternity

Mandatory training

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

Midwifery staff received and kept up to date with their mandatory training. Data showed a compliance rate of 89.25 % and above for midwifery staff completing mandatory training across the trust.

Medical staff received and kept up to date with their mandatory training. Data showed a compliance rate of 81.5 % and above for medical staff completing mandatory training across the trust.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed professional obstetric multidisciplinary training (PrOMPT) training once a year. Data showed as of June 2023, 74% of midwives, 82% obstetric consultants, 91% obstetric trainees and 53% anaesthetic consultants across the trust had completed yearly PrOMPT training. Trust data showed staff were booked onto PROMPT training and predicted compliance by the end of the training year was 98% for midwives, 100% for obstetric consultants and trainees and 80% for anaesthetic consultants.

Staff completed regular skills and drills training. For example, staff had completed pool evacuation and responding to baby abduction drills. Midwives completed an emergency pool evacuation live simulation and photographs of this activity were taken to add to the emergency pool evacuation procedure that was updated in February 2023. The service planned to develop a video for staff documenting a safe evacuation from the pool, however, we were not told of an anticipated completion date for this.

Training included cardiotocograph (CTG) competency, skills and neo-natal life support. Compliance with CTG training as of 30 May 2023 was at 96% for midwifery staff, 77% for obstetric consultants and 82% for obstetric trainees. Ninety one percent of midwives and 92% of medical staff had completed a competency assessment for CTG training. Ninety three percent of midwifery staff and 93% of obstetric staff had completed training in neonatal life support.

Managers monitored mandatory training and alerted staff when they needed to update their training. The majority of staff we spoke with including newly trained midwives, experienced midwives and medical staff told us they were able to access the training they required and were positive about the training and support they received.

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.

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with, had completed online safeguarding training in the past year. As of June 2023, midwifery staff compliance with safeguarding adults and children level 3 was 97%. For medical staff safeguarding training compliance was 83.5% for safeguarding adults and children level 3.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the safeguarding team which was made up of safeguarding specialist midwives and perinatal mental health midwives who oversaw the care of vulnerable women and birthing people having babies at St James's University Hospital.

Maternity

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act.

Midwives were alert for potential safeguarding concerns at each contact with woman and birthing people. For example, they asked woman and birthing people if they experienced domestic violence. Midwives referred to specialist teams if safeguarding concerns were identified. There was a specialist team to support teenage pregnancies. The 'Haamla' team supported women, birthing people and their families from ethnic minority communities including asylum seekers and refugees. Safeguarding specialist midwives attended multi-disciplinary meetings with lead agencies (the local authority) to discuss current safeguarding concerns and policy updates.

Staff followed the baby abduction policy and undertook baby abduction drills. The service was in the process of having a 'baby tagging' system installed on labour and postnatal wards in order to improve the risk management of baby abduction.

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.

Staff followed infection control principles including the use of personal protective equipment (PPE). Data showed hand hygiene audits were completed every month in all maternity services. Between March and May 2023 compliance for hand hygiene audits was consistently at 100% compliance.

Managers completed PPE audits across all maternity areas. Staff wore appropriate protective equipment and were bare below the elbow when in clinical areas to reduce the risk of infection. Women, birthing people and families we spoke were happy with the standards of cleanliness they found at the hospital.

The service generally performed well for cleanliness. Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to show equipment was clean and ready for use.

The service was visibly clean in all areas. Housekeepers followed weekly and daily cleaning schedules. Cleaning audits for February, March and April 2023 recorded compliance rates of 97.98% and above with expected cleaning standards.

Leaders monitored infections rates in labour and postnatally. Between December 2022 and May 2023, there were two incidents of sepsis in maternity services across the trust and both incidents occurred in the postnatal period.

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.

The design of the environment followed national guidance. The maternity unit was fully secure. There was a monitored buzzer entry system to the maternity unit.

Maternity

St James's University Hospital is an older building and because of this some of the estate was not fit for purpose. For example, the Snowdrop Bereavement Suite was not in use. Mothers who experienced pregnancy loss were cared for at the Leeds General Infirmary site while work was being carried to improve this facility.

The service had two maternity theatres and three high dependency beds for women and birthing people requiring a higher level of monitoring after delivery.

During the inspection we saw women and birthing people could reach call bells in the ward areas and staff responded quickly when called. However, feedback from women, birthing people and their families following our inspection indicated ongoing issues with staff not responding to call bells in a timely manner on the postnatal ward.

Staff carried out daily safety checks of specialist equipment. Staff used an electronic system to check emergency equipment. This system showed very few (2) exceptions for checking equipment in May 2023 and where gaps were identified, these were escalated to ward managers for follow up.

The service had enough suitable equipment to help them to safely care for women, birthing people and their babies. The service kept an equipment register, which showed all medical devices were in date for servicing.

Staff disposed of clinical waste safely and sharps bins were labelled correctly.

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.

Staff had access to but did not consistently use an evidence-based, standardised risk assessment tool for maternity triage. This tool rated the urgency of obstetric review needed from red, the most urgent (immediate transfer to labour ward and obstetric review) to green the least urgent (junior obstetric review needed in 4 hours). Maternity assessment centre (triage) audits showed in May 2023 the priority rating for women admitted through the maternity assessment centre was recorded in 46% of cases and between January and May 2023 compliance ranged between 41.5% and 51.5%. The service was aware of this risk and was part of a local maternity and neonatal system (LMNS) working group to improve the telephone triage service across the region.

Women and birthing people in maternity triage were seen in a timely way. Triage audits showed between 1st January 2023 until 31st May 2023 midwives were correctly prioritising women and birthing people using algorithms and appropriately requesting medical reviews and escalation of patients. however, there was on going issues with the wait for medical review.

There was a risk to women and pregnant people waiting in the unobserved waiting area within triage, some of whom were waiting in this area for up to four hours or more. There was very little information about how they should summon support should their health deteriorate. We escalated this to leaders during the inspection and the trust took immediate action to monitor the number of patients required to wait in this unobserved waiting area and provided a portable buzzer so women and pregnant people could summon support should they need to. As well as this a request was submitted to Estates and Facilities for a window to be inserted in the corridor wall to facilitate visual observation of the waiting area by maternity assessment centre staff.

Maternity

Managers did not monitor the timeliness of the response to triage phone or the call abandonment rate calls this meant there was no oversight of how long women and birthing people were waiting to get through or if and how many calls were abandoned.

Staff used a nationally recognised tool to identify people at risk of deterioration and escalated them appropriately. Staff used maternal early obstetric warning score (MEOWS). Managers completed MEOWS audits twice a year. The March 2023 MEOWS audit showed of 69 records checked across the trust 81% of MEOWS observations were completed on time. None of the 19% remaining records included in the audit needed escalation. Managers planned to increase the frequency of the audit to monthly and deliver targeted training to staff on MEOWS frequency and escalation.

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle. The service had worked to improve rates of antenatal glucose tolerance testing by creating a searchable electronic list of the countries of origin that need a glucose tolerance test to test for gestational diabetes. There were clear criteria for use of the birth pool.

Staff knew about and dealt with any specific risk issues. For example, staff used a 'fresh eyes' approach to ensure fetal monitoring was carried out safely and effectively. Managers audited compliance with fresh eyes reviews of women and birthing people being continuously monitored during labour. Data from the October 2022 to April 2023 audit showed hourly CTG categorisation was completed in 19 out of 20 (95%) cases and 'fresh eyes' were completed at each hourly assessment in 13 out of 20 cases. Occasional missed fresh eyes (once or twice throughout labour) were found in 5 out of 20 cases (25%). Reasons for omissions included change of midwife for a break, shift changes or the second stage of labour. The service had an improvement plan that included actions such as the fetal monitoring team working to improve CTG categorisation and fresh eyes compliance in the second stage of labour through staff communications and teaching on the fetal monitoring study day. Midwives had access to the fetal monitoring team for support on CTG interpretation.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of deteriorating mental health during pregnancy. Staff screened women and birthing people for depression using a specific questionnaire referred to as the 'Whooley questions.' Women and birthing people we spoke with told us staff asked about their mental health and wellbeing at every contact.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. Managers monitored the effective use of handover of care and the SBAR tool. Managers told us they monitored the use of SBAR tool and quality and effectiveness of handovers. Results of the May 2023 SBAR audit showed 95% of women had an SBAR tool completed for all transfers.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed between April 1st and 30th June 2023 showed checklists were consistently completed in full.

Staff had access to a critical care outreach team to support management of deteriorating patients. Midwives could contact the team 24/7.

Maternity

Women and birthing people who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with a specialist midwife to discuss risks and options available to create a suitable birth plan together. In addition to this the pregnant women or person would have an appointment with a consultant obstetrician before making their final decision about labour and birth. Birth plans were shared with the multidisciplinary team.

Staff completed new-born risk assessments when babies were born using recognised tools and reviewed this regularly. New-born and infant physical examination clinics were held daily on the postnatal ward and staffed with midwives who had additional training to carry out these checks.

The service had Four rooms on the postnatal ward which were used for transitional care and these were staffed with neo natal trained staff.

Shift changes and handovers included all necessary key information to keep women, birthing people and babies safe.

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

Midwifery Staffing

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

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Most of the time, the service had enough nursing and midwifery staff to keep women, birthing people and babies safe. Managers used a workforce acuity tool to monitor midwifery staffing against workload across the trust maternity services. Delivery suite coordinators completed the tool every four hours and as needed. In March 2023 staffing levels were adequate for the level of activity at St James Hospital.

Patient flow coordinators had oversight of staffing numbers and needs within maternity services. Daily meetings were held to review staffing and decide action to ensure safe staffing levels. Ward staff escalated any staffing concerns to patient flow co coordinators, at times staff were moved to different departments in order to provide staffing cover.

Feedback from women and birthing people during the inspection was positive, they told us there were enough staff to meet their needs. However, feedback from women, birthing people and their families following our inspection indicated there were not enough staff on the postnatal ward and they were kept waiting for pain relief and support or did not get the support they required.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. Leaders completed a maternity safe staffing workforce review in line with national guidance the head of midwifery reported to the quality assurance committee in April 2023 that the last staffing review recommended an establishment of registered clinical midwives of 363.6WTE. As of the end of February 2023 the trust had 339.55 WTE midwives contracted in post. This gives a vacancy rate of 24.25 WTE which is 6.66% of the funded establishment. The average attrition rate for midwives was consistently 3 WTE a month at the time of inspection.

Maternity

The service had reducing turnover rates. The service had appointed a recruitment, retention and preceptorship midwife who focused on supporting midwifery induction professional development. At the time of inspection midwifery staffing was a recorded risk due to a high number of staff on maternity leave and long-term sickness.

Managers limited their use of bank and requested staff familiar with the service. Managers monitored use of bank staff and did not use agency midwifery staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance with yearly appraisals for midwifery staff was at 75% and above except within antenatal clinics and day assessment unit which was at 42.86%. However, we were not aware of the trust target for the completion of appraisals.

Managers made sure staff received any specialist training for their role. All core band 7 and band 6 midwives caring for women after surgery on the delivery suite completed the PROMPT Care of Critically Pregnant or Postpartum Woman (CIPP) training. The service also prioritised these midwives for completion of the Yorkshire & Humber Maternal Enhanced & Critical Care competency passport. This learning passport includes assessment of the skills and knowledge needed to assess and escalate signs of deterioration.

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 on labour ward. The service had17 consultant obstetricians and 4 locum consultants on long term contracts of one year or more. The service prioritised medical staffing on the labour ward to keep women, birthing people and babies safe. The labour ward had 98-hour consultant obstetrician cover on site with twice daily consultant led ward rounds on labour ward. This was in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth Guidance on minimum standards for the organisation and delivery of care in labour for maternity units with 4000 to 5000 births a year.

The service always had a consultant on call during evenings and weekends and resident obstetric consultant cover overnight. The service 17 consultant obstetricians, 4 locum consultant obstetricians on long-term contracts of 1 year more. Consultants covered a 1:10 obstetric consultant on call rota for Leeds General Infirmary and St James's University Hospital. Each site had a 'consultant of the week' to ensure continuity of care.

There was no designated consultant obstetrician staffing to the medical assessment centre. Midwifery staff were supported by a middle grade doctor who covered labour ward and maternity assessment Monday to Friday 08:30am to 5pm and outside of these hours a middle grade doctor covered the maternity wards and maternity assessment centre. The availability of a middle grade doctor impacted on the timeliness of medical review for priority 2 women.

Sickness rates for medical staff were reducing. At the time of inspection there were gaps in the middle grade rota due to long term sickness of junior doctors.

The service had reducing rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Data showed between 1 April 2022 and 31 March 2023 100% of medical staff received an appraisal.

Maternity

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.

Notes were comprehensive, and all staff could access them easily. The trust used a fully electronic records system. We reviewed 6 records on inspection and found records were clear and completed.

Managers audited 20 maternity records every month to ensure staff were completing them correctly.

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.

There was a recorded risk on the risk register in relation to the prescribing process for epidurals…

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people about their medicines. Staff completed medicines records accurately and kept them up to date. All the medicines records we reviewed were clear and up to date.

Staff had access to medicines used to respond to emergencies safely. On delivery suite, staff had access to emergency 'grab boxes' to respond to conditions such as pre-eclampsia, sepsis and cord prolapse.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women 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. Staff raised concerns and reported incidents and near misses in line with trust policy. For example, a near miss in theatres during an emergency caesarean section was reported and learning shared in the April 2023 Women's clinical service unit monthly 'sharing the learning' newsletter. Managers thanked staff for speaking up and encouraged staff to remain vigilant against the risk of retained swabs.

Staff reported serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent and gave women, birthing people and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning from incidents in the monthly newsletter. The April 2023 Women's CSU monthly 'sharing the learning' newsletter included safety reminders. Learning from serious incidents was also shared in this newsletter. For example, learning from a Healthcare Safety Investigation Branch (HSIB) report that found systems and processes for ensuring women's clinical observations were easily available to all staff could be improved. Staff were reminded to ensure all MEOWS scores were authenticated by a registered professional.

Staff met to discuss the feedback and look at improvements to the care of women. Managers attended a weekly rapid review meeting to review recent incidents.

Managers investigated incidents thoroughly. We reviewed one patient safety incident that was finalised in February 2022 We reviewed the last 3 incidents reported to HSIB. Managers completed action plans following completion of the investigations with targets for completion for implementing the recommendations.

Managers debriefed and supported staff after any serious incident. The service was formalising the debriefing process as part of a quality improvement project to include hot debriefs immediately after the event and cold debriefs later after the event. The service had recently recruited a clinical psychologist to support this work.

Is the service well-led?

Good

We rated well-led as good.

Leadership

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

Maternity services at St James Hospital were managed as part of the Women's Clinical Service Unit (CSU). The Women's CSU across the trust was managed by a director of midwifery, a head of midwifery, a clinical director and a general manager. The head of midwifery was supported by a deputy head of midwifery and six matrons with responsibility for gynaecology, intrapartum care, community, outpatients, antenatal and postnatal care, governance and quality.

The Women's CSU triumvirate leadership team met every month to discuss workforce,

We observed on inspection and staff told us that leaders above matron level were not always visible. Following the inspection the trust told us they planned to formalise the programme for leadership walkabouts with weekly triumvirate walkabouts and monthly safety champion walkabouts in person.

The head of midwifery met with the board maternity safety champion bi-monthly . The Deputy Director of Midwifery, Clinical Director, neonatal leadand maternity voices chairs also attended this meeting. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and an advocate for the service at board level.

Information on how to contact the women's CSU leadership team and the maternity safety champions was displayed in the maternity unit.

The workforce vision and strategy included plans to review and map out career pathways for staff in the Women's CSU from band 2 to senior leadership roles.

Maternity

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 Women's CSU Quality and Safety Plan 2022-2023 was aligned with 'The Leeds Way' values of being patient centred, collaborative, fair, accountable and empowered. The vision for the CSU was "being better tomorrow than we are today."

The head of midwifery shared a short video update about the Women's CSU workforce strategy and vision in February 2023 defining the vision as having a "skilled and big enough workforce to deliver excellent services." The workforce vision also focuses on ensuring the workforce is diverse, staff are valued and have fair access to professional development. The workforce shared vision was developed with staff at a workforce 'time-out day' in November 2022.

The maternity leadership team were awaiting the single plan before creating a new set of strategies for maternity services.

Culture

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

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas.

Staff understood the policy on complaints and knew how to handle them. The service had a process for de-escalating complaints to resolve women's concerns about their care in a less formal way.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. Between 1 December 2022 and 31 May 2023 the trust received 19 complaints in relation to maternity care. Managers investigated and responded to formal complaints within 20, 40 or 60 days depending on the complexity of the complaint. The Women's CSU had a dedicated patient experience role and a specialist midwife for complaints. The service always offered a resolution meeting with complainants.

Leaders had a strong focus on staff wellbeing. The service was involved in an NHS England pilot on staff wellbeing and following feedback from the staff survey had employed a psychologist to support staff. The trust had 'wellbeing champions' and a wellbeing newsletter that included help and advice such as financial wellbeing tips, links to courses and peer support groups.

Staff we spoke with told us they were well supported and felt valued by the trust. The trust had a staff recognition scheme and the service had run an awards ceremony just for Women's CSU staff on International Day of the Midwife in May 2023. Staff we spoke with were positive about this event and the comments they received from staff nominations.

The workforce strategy included actions to embed the 'Civility Saves Lives training and ways of working into the culture.

Maternity

Staff we spoke with were consistently positive about working at the hospital and told us they felt well supported and able to raise concerns when needed.

Governance

Leaders operated effective 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 monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. These included: trust bi-annual reviews of the CSU risk registers at risk committee, Women's CSU governance forum monthly, sub-speciality governance meetings for community and outpatients, inpatients and maternity assessment centre, and intrapartum care.

Staff were supported by a Women's CSU quality and safety team. Midwifery staff who were working clinically were seconded into the quality and safety team every year on a rolling basis to ensure there were midwives with current clinical knowledge on the team and to improve the governance awareness of clinical staff.

We reviewed extracts of maternity updates to the trust quality assurance committee that were presented every other month by the director of midwifery or the head of midwifery. The meetings were chaired by the non-executive director board level maternity safety champion. The head of midwifery presented a maternity services assurance report every other month that included updates on progress against the Ockenden immediate and essential actions, the maternity incentive scheme, the three-year delivery plan for maternity and neonatal services, health and wellbeing, training and education, workforce.

We reviewed minutes of the last 3 Women's CSU governance forum meetings attended by the director of midwifery, general manager for women's services and the clinical director. A standard agenda was used to discuss the risk register and mitigating actions, the maternity dashboard, the perfect ward dashboard, leadership walkarounds and external visits.

We reviewed minutes of the last 3 'Perfect Ward' Women's CSU meeting minutes. These meetings were chaired by the head of midwifery and attended by matrons and senior midwives. A standard agenda was used to discuss topics including but not limited to perfect ward audit data, incidents, safeguarding, staffing.

We reviewed minutes of the last 3 Women's CSU matrons' meetings which were attended by maternity matrons across the trust. A standard agenda was used to discuss incidents, complaints, infection control and local audits,

We reviewed the last three quality forum meeting minutes for the sub-speciality groups in maternity that were held every other month. These meetings were attended by a matron, midwifery team leaders and senior midwives from the relevant clinical areas.

The service had a weekly Perinatal Mortality Review tool (PMRT) meeting that was attended by a multidisciplinary team including the Women's CSU quality and safety team, consultants and midwives. There was an ongoing action tracker to monitor learning and improvements. Managers shared learning from PMRT meetings through the monthly 'sharing the learning' newsletter. The service had set up an external peer review process with a local trust of a similar size serving a similar community for PRMT.

The trust had worked in partnership with trusts in the Yorkshire region to compare clinical outcomes and governance processes.

The service also completed a governance peer review process with another local trust to review how incidents were graded.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed policies in relation to induction of labour and the maternity assessment centre. These were in line with national guidance. Managers monitored clinical guidelines due for approval through the quality forum meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Top risks across maternity services at the Leeds General Infirmary and the St James's University Hospital site, nitrous oxide exposure, risk of baby abduction and sonography staffing impacting on the availability of scans.

The nitrous oxide exposure risk was mitigated by improving the use of gas scavenging systems which were installed at the Leeds General Infirmary but not routinely used by staff and rotating staff to ensure exposure to nitrous oxide was minimised.

The baby abduction risk was mitigated by the security measures such as CCTV and locked doors with a buzzer entry system. The service regularly completed abduction drills and was in the process of purchasing an electronic baby tagging system to improve security.

The sonography staffing risk was mitigated by using an external provider to provide additional scan slots.

Maternity leaders escalated risks to the trust board through the risk management committee meeting. We reviewed meeting minutes for the June 2023 and December 2022 meetings and saw the management of significant risks such as the lack of electronic baby tagging and staffing challenges with the administrative workforce were discussed, and the risk scores reviewed and agreed.

Managers carried out a comprehensive programme of repeated audits to check improvement over time. The service had a yearly audit programme and participated in relevant national clinical audits. For example, the service participated in the national maternity and perinatal audit and the national diabetes in pregnancy audit. The service collected data on 3rd and 4th degree tears, also known as an obstetric anal sphincter injury (OASI) and held an OASI clinic to follow up on women who have experienced this type of trauma. Leaders reviewed performance in audits monthly through Women's CSU governance meetings.

The maternity dashboard compared outcomes to national averages and standards as well as regional services. Data showed as of March 2023 the total rolling annual number of stillbirths at term was 5 and the rolling total still birth rate was 3.59. This was in line with the national average of 4.1 were stillbirths for every 1,000 births. Data showed in the last 12 months there were between 41 and 68 avoidable term admissions to the neonatal unit and in the past year the post-partum haemorrhage of over 1500ml rate ranged between 3.13% and 4.46% against a target of below 3.29%.

Maternity

The service was focused on reviewing health outcomes to improve health equity in maternity services. The service completed a 12-month review of stillbirths and a 5-year review of stillbirth by maternal ethnicity to understand if disparities existed. The consultant midwife for health equity and an obstetric registrar led work on an audit of reduced fetal movements which highlighted disparities in the presentation of different cohorts of women for reduced fetal movements.

Leaders monitored compliance with the Ockenden review mandatory actions to improve safety of maternity units regularly at the trust quality assurance committee that was a sub-committee of the trust board. The last Ockenden review update to the quality assurance committee in April 2023 showed the trust was compliant with all 7 immediate essential action and twelve clinical priorities from the 2020 Ockenden report.

The service was fully compliant with year 4 of the NHS Resolution maternity incentive scheme. Recent audits showed the service met all 10 safety standards. Leaders updated the trust board on compliance with the maternity incentive scheme in January 2023.

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 used a fully electronic patient record system.

The trust employed a Deputy Chief Midwifery Information Officer. The trust was the first organisation to create such a senior role for a digital midwife. The service had created a Maternity Health Inequalities Dashboard to review maternity data through a population health management lens reviewing social profiles and medical complexity across the city. The service used data from the dashboard to inform a business case for increased funding for gestational diabetes clinics due to increased prevalence of gestational diabetes. Data from the dashboard was also used to target smoking cessation advice across 7 high prevalence smoking areas in Leeds.

The service used statistical process control SPC (charts) alongside the maternity dashboard to review statistically significant trends in clinical outcomes. For example, the March 2023 SPC maternity dashboard reported a statistically significant reduction in the post-partum haemorrhage rate PPH rate can be seen. This improvement was seen following a sustained quality improvement project within the maternity services.

Engagement

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

The service welcomed feedback from women, birthing people and families. People could feedback to the service through surveys, complaints and through the local maternity voices partnership (MVP).

The service had good links with the local MVP, and they were involved in the governance of the service, including the bi-monthly safety champions meetings. In April 2023 the service increased the funding for the MVP chair role from 11 hours

to 21 hours a week to increase their capacity to support codesign of maternity services. The service worked with the MVP to carry out a focus group with Black African women in a socially deprived neighbourhood of Leeds. The aim of the focus group was to explore perceptions of maternity care and understanding of maternity information to inform improvements to the inclusivity of the service.

The consultant midwife for health equity and consultant obstetrician with a specialist interest in health equity service worked with a media company to capture the voices of nine local women in Leeds who were part of communities at greater risk or poor maternal and neonatal health outcomes.

The CQC Maternity Survey results for 2022 showed, in comparison to other trusts, Leeds Teaching Hospitals NHS Trust scored 'much better', 'better' or 'somewhat better' than expected for 15 questions, 'worse than expected' for one question and 'about the same as expected' for 35 questions.

Most of the questions where the trust scored better than other trusts related to antenatal care. The one question where the trust scored worse than other trusts related to women and birthing people feeling listened to by their midwifery team during postnatal care.

The 2022 General Medical Council National Trainee Survey (GMC NTS) which trainees complete in relation to the quality of training and support received, showed scores for most indicators, including 'overall satisfaction' were similar to the national average. Leeds General Infirmary was in the lower (i.e. worst) quartile, but not an outlier, for two metrics out of 19 metrics. This was a deterioration from 2021, when the trust was only in the lower quartile for one measure.

The board safety champion ran open forums both virtual and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries.

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.

Staff were supported to complete quality improvement projects. Staff had access to the women's CSU 'Quality Improvement Crew.' Staff could submit ideas to the 'QI crew' and then get support to develop the project. For example, the QI team supported the development of a pre-term specialist birth team of 2 midwives and a maternity support worker to provide continuity of care for pregnant people at risk of preterm birth. The pre-term specialist birth team improvement project led to an improvement in % women aged under 25 offered chlamydia and gonorrhoea screening at booking from 4% at the start of the project in January 2022 to 69% in March 2023.

The service had an active reproductive health and childbirth research team. The service was part of a national research trials including but not limited to the Giant Panda study which aims to find out which is the best medication (labetalol or nifedipine) to treat high blood pressure in pregnant women. All pregnant women were invited to join the Born and Bred in Leeds (BABi) study to link routine data to create a more complete picture of local families' lives with the aim of using this information to support improvements in health and social care.

Maternity

Outstanding practice

- The service had a strong focus on health equity. The service employed a health equity consultant midwife since October 2022 and was recruiting two WTE band 6 midwives to this team at the time of inspection.
- The Deputy Chief Midwifery Information Officer and a consultant obstetrician had worked with the trust IT team to create a maternity health inequalities dashboard using Patient Level Costing (PLICs) information.
- Prematurity midwives provide caseload care for women with risk factors for premature birth.

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 SHOULD take to improve :

Maternity at St James's Hospital

- The service should ensure that staff consistently record triage risk assessments.
- The service should ensure the timeliness of response to triage phone calls and call abandonment rates are monitored.
- The service should ensure women and birthing people in the triage waiting room know how to summon help and are monitored.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, two midwifery specialist advisors and an obstetrician specialist advisor. The inspection team was overseen by Carolyn Jenkinson Deputy Director of Secondary and Specialist Healthcare.