

Leicester University Hospitals NHS Trust

# Leicester Royal Infirmary

## Quality Report

Leicester Royal Infirmary,  
Infirmary Square,  
Leicester  
LE1 5WW

Tel: 0300 303 1573

Website: [www.leicestershospitals.nhs.uk](http://www.leicestershospitals.nhs.uk)

Date of inspection visit: 8 May 2019

Date of publication: 13/08/2019

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

University Hospitals of Leicester NHS Trust is a teaching trust and was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,993 general and acute beds. Of these beds, 147 are maternity beds and 49 are critical care beds.

University Hospitals of Leicester NHS Trust provide specialist and acute services to a population of one million residents throughout Leicester, Leicestershire and Rutland. The trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country. The trust provides services from three hospital sites, Leicester Royal Infirmary, Leicester General Hospital and the Glenfield Hospital.

Leicester Royal Infirmary is close to Leicester city centre and provides Leicestershire's only emergency department. The hospital has approximately 937 inpatient beds and 85 day-case beds.

We carried out an unannounced inspection of maternity wards at the Leicester Royal Infirmary on 8 May 2019 in response to three incidents reported by the trust between January and May 2019. The inspection was not intended to re-rate the service. The previous ratings of the maternity service will still stand and will not be affected by this inspection.

We did not inspect any other core services or wards at this hospital. During this inspection we focussed on the key questions of safe and well led.

There were some areas where the trust needs to make improvements.

Importantly, the trust must:

- Ensure there is sufficient consultant presence in Maternity Assessment Unit (MAU).
- Ensure there is clear escalation guidance for staff in MAU when medical staff are busy or unavailable.

In addition, the trust should:

- Ensure the MAU phone line is managed effectively, including timely triage and advice for women.
- Ensure the physical environment of MAU provides privacy for assessments of women and staff handovers. Also, privacy for staff managing phone calls into MAU.
- Ensure the abdominal pain guidance and pre-term labour guidance link with each other and include current NICE guidance and recommendations.
- Ensure the requirement notice relating to equipment servicing from the previous inspection is met.

Professor Ted Baker Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

### Maternity (inpatient services)

### Rating Why have we given this rating?

We did not re-rate this service. During this inspection we found:

- There was not always sufficient consultant presence in Maternity Assessment Unit (MAU).
- Staff tried to manage the MAU phone line as well as care for women attending the unit which meant triage of women calling the unit was often delayed.
- The physical environment of MAU did not provide privacy for assessments of women, staff handovers or for staff managing phone calls into MAU.
- **The service had guidance on abdominal pain in pregnancy and guidance on pre-term birth, however, these were not linked as easy reference for staff. Also, the abdominal pain in pregnancy guidance did not include current NICE guidance and recommendations.**
- **Two pieces of essential equipment in MAU were not serviced within the due date.**
- Serious incidents were identified and investigated but action to improve the service was not always taken in a timely way.
- Not all equipment in Maternity Assessment Unit (MAU) was serviced within date, despite this being raised for the maternity service at the previous inspection.

However:

- The service had enough midwives to care for women attending Maternity Assessment Unit (MAU).
- The service identified and investigated incidents within timescales and kept women and families informed.
- The service had made some improvements following recent incidents.
- The service had governance structures in place to manage incidents.
- Learning from serious incidents was shared with staff in a timely way.
- Managers used various formats to promote sharing and learning with staff.

# Leicester Royal Infirmary

## Detailed findings

### Services we looked at

Maternity (inpatient services)

# Detailed findings

## Contents

Detailed findings from this inspection	Page
Background to Leicester Royal Infirmary	5
Our inspection team	5
How we carried out this inspection	5
Action we have told the provider to take	14

## Background to Leicester Royal Infirmary

University Hospitals of Leicester NHS Trust is a teaching trust was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. There are 937 inpatient beds and 85 day-case beds are located at Leicester Royal Infirmary.

University Hospitals of Leicester NHS Trust provide specialist and acute services to a population of one million residents throughout Leicester, Leicestershire and Rutland. The trust's nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

Leicester, Leicestershire and Rutland have a population of approximately 1.03 million, with 32% of people living in the city, 64% in Leicestershire and 4% living in Rutland.

The three areas have significant differences. The city of Leicester has a younger population, whilst the county areas have an older population. The city of Leicester is an ethnically diverse population with over 37% of people being of Asian origin.

In Leicester city, 75% of people are classified as living in deprived areas and there are significant problems with poverty, homelessness and low educational achievement. In Leicestershire over 70% of people are classified as living in non-deprived areas, although there are pockets of deprivation and in Rutland, over 90% of people are classified as living in non-deprived areas. Demographic and socio-economic differences manifest themselves as inequalities in health and life expectancy in the city is 5.6 years less than in Rutland amongst men and 2.5 years less amongst women.

## Our inspection team

Our inspection team was led by:

**Karen Richardson: Inspection Manager**, Care Quality Commission

The inspection team also included three CQC inspectors and one maternity specialist advisor.

## How we carried out this inspection

The Care Quality Commission carried out an unannounced inspection of maternity services on 8 May 2019.

During the inspection, we carried out a number of activities to gather evidence, examining trust action plans, policies and processes, staff interviews, direct observations of patient care and a review of patient records.

# Detailed findings

We visited the Maternity Assessment Unit (MAU)

We:

- Spoke with eight members of staff including midwives, ward managers, matrons, doctors and support staff.
- Reviewed one prescription chart.
- Reviewed guidelines, guidance and policies.

# Maternity (inpatient services)

Safe

Well-led

Overall

## Information about the service

Maternity services at the trust are delivered across three sites – Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and St Mary's Birth Centre in Melton Mowbray. All three of the sites have midwife-led units, with additional consultant-led delivery suites at LRI and LGH for more complicated pregnancies. The trust also has a home birth team consisting of midwives to care for 'low risk' women in the community.

(Source: Trust website)

### Facts and Figures

From January to December 2018, there were 9,293 deliveries at the trust, a 2% decrease when compared to 9,459 deliveries in the period from January to December 2017.

When looking at the type of deliveries at the trust from January to December 2018, 56.2% of deliveries were non-interventional, 31.2% were caesarean section and 12.4% were instrumental deliveries.

The Trust has 149 maternity beds across three sites:

LGH - Labour Ward/Delivery Suite (19 beds)

LGH - Ward G30 33 (beds)

LRI - Delivery Suite - Ward RLWM (24 beds)

LRI - Ward 5 (26 beds)

LRI - Ward 6 (26 beds)

St Marys Birthing Centre (8 beds)

## Summary of findings

We did not re-rate this service. During this inspection we found:

- There was not always sufficient consultant presence in Maternity Assessment Unit (MAU).
- Staff tried to manage the MAU phone line as well as care for women attending the unit which meant triage of women calling the unit was often delayed.
- The physical environment of MAU did not provide privacy for assessments of women, staff handovers or for staff managing phone calls into MAU.
- The service had guidance on abdominal pain in pregnancy and guidance on pre-term birth, however, these were not linked as easy reference for staff. Also, the abdominal pain in pregnancy guidance did not include current NICE guidance and recommendations.
- Two pieces of essential equipment in MAU were not serviced within the due date.
- Serious incidents were identified and investigated but action to improve the service was not always taken in a timely way.
- Not all equipment in Maternity Assessment Unit (MAU) was serviced within date, despite this being raised for the maternity service at the previous inspection.

However:

- The service had enough midwives to care for women attending Maternity Assessment Unit (MAU).
- The service identified and investigated incidents within timescales and kept women and families informed.
- The service had made some improvements following recent incidents.
- The service had governance structures in place to manage incidents.

# Maternity (inpatient services)

- Learning from serious incidents was shared with staff in a timely way.
- Managers used various formats to promote sharing and learning with staff.

## Are Maternity (inpatient services) safe?

We carried out an unannounced inspection of maternity wards at the Leicester Royal Infirmary on 8 May 2019 in response to three incidents reported by the trust between January and May 2019. The inspection was not intended to re-rate the service. The previous ratings for safe for the maternity service will still stand and will not be affected by this inspection.

During this inspection we found:

- There was not always sufficient consultant presence in Maternity Assessment Unit (MAU). Women attending MAU often waited several hours to see a doctor.
- Staff tried to manage the MAU phone line as well as care for women attending the unit which meant triage of women calling the unit was often delayed.
- The physical environment of MAU did not provide privacy for assessments of women, staff handovers or for staff managing phone calls into MAU.
- The service had guidance on abdominal pain in pregnancy and guidance on pre-term birth, however, these were not linked as easy reference for staff. Also, the abdominal pain in pregnancy guidance did not include current NICE guidance and recommendations.
- Two pieces of essential equipment in MAU were not serviced within the due date.

However:

- The service had enough midwives to care for women attending Maternity Assessment Unit (MAU).
- The service identified and investigated incidents within timescales and kept women and families informed.
- The service had made some improvements following recent incidents.

### Incidents

- Between January and May 2019 there were three serious incidents relating to the maternity service and specifically involving the Maternity Assessment Unit (MAU).
- We saw the investigation reports for the incidents and saw that the service had taken learning forward.



# Maternity (inpatient services)

- The service produced a learning bulletin following the outcome of investigations which was shared with staff. This included details of the incident, findings, recommendations and actions for staff.
- The service had produced action plans following the incidents. We found some of the key actions had completion dates which were months after the date of incident. We asked senior managers about this who said the Safety team set the target dates. Following our inspection, the dates were amended to shorter timeframes.
- Senior managers told us improvement actions following the incidents were planned and were underway. We saw that some actions had been taken, such as women having a named midwife during their journey in the MAU. However, other important improvements to keep women and babies safe were not yet underway despite several weeks since the first incident occurred. For example, the new task and finish group for MAU was due to meet for the first time two days after our inspection.
- Staff had submitted 14 incident reports between April 2018 and April 2019 for women waiting several hours for review by a doctor. However, staff felt this number was lower than the actual figure due to midwives being too busy to complete incident reports. We saw a log of long waiting times staff had completed in MAU for April 2019. This showed women regularly waiting for than four hours in MAU and staff had noted the reason as awaiting review by a doctor.
- Duty of candour is a regulatory duty related to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had carried out duty of candour with the families following the three incidents.
- Staff met at monthly perinatal review group (PRG) meetings where staff discussed learning from incidents. This fed into the monthly maternity governance meetings.
- Senior managers told us following a serious incident, all staff were invited to a de-briefing session. The session was a safe place for staff to discuss the incident.

## Safety thermometer

- We did not review safety thermometer.

## Cleanliness, infection control and hygiene

- We did not review cleanliness, infection control and hygiene.

## Environment and equipment

- The Maternity Assessment Unit (MAU) physical environment meant there was no privacy for staff handovers or assessments of patients in bays. Staff answered the phone line into MAU at the nurse's station which did not provide privacy for triage and advice. Senior managers told us they planned to improve the privacy with a glass screen but there were no dates for completion.
- The waiting area within the MAU was small and cramped and very close to the nurse's station and assessment bays. Staff told us women could be waiting in the area for up to five hours. This was supported by a staff log of waiting times for women.
- We saw two pieces of equipment in MAU were out of date with servicing. A cardiotocograph (CTG) machine was due for a service in February 2019 and a resuscitaire (equipment used for warming and resuscitation of a baby) was due for a service in March 2019. Staff told us the services had been completed but the stickers had not been put onto the machines. However, the servicing was missing from the service book. Managers took immediate action during the inspection to ensure the machines were serviced. Staff had omitted checks for a resuscitaire machine on several dates between 12 February 2019 and 8 May 2019.
- We found the door to the sluice in MAU was not locked and there were cleaning products out on the side. We raised this with staff who then kept the door locked.

## Medicines

- We reviewed medicine storage in the Maternity Assessment Unit (MAU) and found these to be in line with national standards. There were no controlled drugs stored on MAU. Staff recorded fridge temperatures and noted where action had been taken when temperatures were out of the expected range. Storage of medications and fridge temperatures monitoring, and appropriate corrective measures were raised as concerns at the previous inspection.
- Medicine requiring cold storage was kept in a locked fridge in all areas we visited.
- We reviewed one prescription chart which was completed appropriately, and the woman's allergies and weight were documented.

# Maternity (inpatient services)

## Records

- We did not review records.

## Safeguarding

- We did not review safeguarding.

## Mandatory training

- We did not review mandatory training.

## Assessing and responding to patient risk

- We found that there was a lack of consultant presence in Maternity Assessment Unit (MAU). There was one consultant ward round in the morning and then no consultant presence on the ward for the rest of the day. Junior doctors carried out assessments on women in MAU and went to another floor in the hospital to find a consultant to check decisions.
- There was a covering registrar on duty at all times, but they could not always answer the bleep if busy with another woman. Managers told us midwives made decisions regarding low risk care or refer to medical staff if required. Following our inspection, senior managers told us escalation guidance was in place. However, we did not see this at the time of the inspection. Also, senior managers told us out of hours, support for MAU was provided by the emergency medical staff who may have been in Delivery Suite and unable to attend MAU. If this was the case, the senior midwife in MAU contacted the delivery suite co-ordinator to arrange transfer for assessment and observation or intervention as necessary.
- Staff told us that if a fetal monitoring was abnormal, staff would contact the on-call consultant. If the consultant was too busy or could not attend, the woman was occasionally transferred to the delivery suite to be reviewed. Staff said this was not always appropriate for the woman as it could make them more anxious. Staff said these events were reported as incidents and discussed at risk meetings.
- Staff in MAU did not all feel confident to call the on-call consultant out of hours. Managers told us staff should feel confident to call for advice as that was the protocol. Following our inspection senior managers told us issues were escalated through the delivery suite co-ordinator and on-site SpRs, who escalated to the consultant on-call if appropriate

- Staff in MAU managed calls to the service from women requiring advice. Staff were trying to manage the calls and women being cared for in the unit. Staff told us this was difficult to manage. Midwifery support workers could answer calls but could only take the woman's name, date of birth and date of booking with the service. The midwifery support worker would then ask the woman to wait for a midwife or take details for a midwife to call the woman back. This caused a delay to the triage of women by a midwife. Some women calling the service required urgent medical attention and the advice was delayed. Senior managers told us they had plans to improve the management of the phone line, but we did not see any specific plans in place. We observed the phone line called consistently for half an hour and staff tried to answer calls whilst caring for women in MAU.
- The service had guidance on abdominal pain in pregnancy and guidance on pre-term birth, however, these were not linked as easy reference for staff. Also, the abdominal pain in pregnancy guidance did not include current NICE guidance and recommendations.
- Staff in MAU had started a log of length of waiting time for women in MAU in April 2019. Staff had logged the reason for the wait such as awaiting doctor review, awaiting ward bed or awaiting test results. Staff had created this log to provide data which could be used to drive improvements for women using MAU. We saw in the log that on 33 occasions a woman waited more than four hours in MAU. Staff had noted on 11 occasions the woman was waiting for review by a doctor. Staff had not noted reasons for the four-hour wait.
- Senior managers told us they had implemented named midwives for women attending MAU. They said this provided continuity for women. Also, staff were better informed of women's histories because they were only accountable for their allocated women. This also allowed medical staff to feed back to an allocated midwife, so communication was clearer. Senior managers told us they were about to carry out a three-month review of this new way of working.

## Midwifery staffing

- At January 2019, the trust had 345 WTE midwives.

# Maternity (inpatient services)

- From January to December 2018 the trust had a ratio of one midwife to every 25.9 births. This was similar to the England average of one midwife to every 24.6 births. (Source: NHS Digital Workforce Statistics/Electronic Staff Record).
- At December 2018, the trust had a ratio of 0.14 senior midwives to every midwife. This was worse than the England average of 0.24 senior midwives to every midwife. (Source: NHS Digital Workforce Statistics/Electronic Staff Record).
- Senior managers told us this figure was not accurate and there were always at least two band 7 senior midwives on duty during the day at Leicester Royal Infirmary.
- In the most recent nurse staffing return (March 2019), Leicester Royal Infirmary reported fill rates of 87.5% and 85.1% for day and night hours respectively for nursing and midwifery staff in maternity. (Source: Trust website – Safer Nurse Staffing data – March 2019)
- Senior managers told us they managed staff across the maternity service and rotate staff according to need.
- Senior managers told us the attrition rates of staff in the maternity service was good at 7%.
- At the last inspection, the service received a requirement notice as not all staff providing enhanced care for women had the necessary certificate. Senior managers told us at this inspection that this had been addressed and staff had been trained where needed.

## Medical staffing

- At January 2019, the trust had 39 WTE consultant obstetricians/gynaecologists.
- Consultant obstetricians worked on a rota between 8am and 5pm Monday to Friday. The consultant covered antenatal and postnatal wards and Maternity Assessment Unit (MAU). A junior doctor worked with the consultant for the same areas. Between 5pm and 10pm there was consultant cover from the labour ward. Junior doctors covered the antenatal ward, postnatal ward, labour ward and MAU. During the night the consultant was contactable by phone.

## Are Maternity (inpatient services) well-led?

We carried out an unannounced inspection of maternity wards at the Leicester Royal Infirmary on 8 May 2019 in

response to three incidents reported by the trust between January and May 2019. The inspection was not intended to re-rate the service. The previous ratings for well led for the maternity service will still stand and will not be affected by this inspection.

During this inspection we found:

- Serious incidents were identified and investigated but action to improve the service was not taken in a timely way.
- Not all equipment in Maternity Assessment Unit (MAU) was serviced within date, despite this being raised for the maternity service at the previous inspection.

However:

- Learning from serious incidents was shared with staff in a timely way.
- Managers used various formats to promote sharing and learning with staff.

## Leadership

### Vision and strategy for this service

- We did not review vision and strategy.

### Culture within the service

- Staff in Maternity Assessment Unit (MAU) said they were supported by their ward manager.
- Staff we spoke with in MAU did not always feel confident to call the covering consultant out of hours. Managers said staff should feel confident to call the out of hours consultant, but this was not reflected by what staff told us. Following our inspection senior managers told us issues were escalated through the delivery suite co-ordinator and on-site SpRs, who escalated to the consultant on-call if appropriate.
- Senior managers told us there had been a drive on staff wellbeing. Wards had a care box for staff if they were having a difficult shift which included treats to improve staff morale.

## Governance

- Staff met at monthly maternity governance meetings which were multidisciplinary.
- The service also held monthly perinatal review group (PRG) meetings where staff discussed learning from incidents.

# Maternity (inpatient services)

- Staff held a monthly delivery suite forum across hospital sites. At this meeting the Risk manager led on discussions about action plans following serious incident reports.

## Managing risks, issues and performance

- We had information before the inspection that there were up to four weeks delay in the 12-week growth scan at Leicester Royal Infirmary. Senior managers for the maternity service said there had been delays and the risk was on the service's risk register. Senior managers said they had already started up to six extra scanning clinics a week and were on schedule to reduce the waiting times. The service was also implementing a triage for referrals from other sources such as GPs and community midwives to ensure there was not duplication of scanning appointments for women.
- Senior managers told us the service had arranged training for two midwives in sonography to be able to carry out scans for women and reduce waiting times.
- Senior managers explained scanning dates for women depended on when a woman booked her pregnancy with the service.
- The service had a perinatal mortality review panel with an obstetric consultant lead.

## Managing information

- We did not review how information was managed.

## Public engagement

- The service gathered feedback from patients using "A message to matron" cards. We saw feedback for January to March 2019. The feedback was very positive about care they received. However, patients had consistently raised issues about privacy and waiting times to see a doctor.
- The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The data showed two unusually low data points in January and February 2019 for women on postnatal wards. Senior managers explained that the service had recently allowed partners to stay with women on the

wards. However, the service did not have the facilities for overnight stays and so this had led to complaints. Staff could not offer food or drink or bedding to partners.

- The service was working with local community groups to understand cultural reasons why women may book late with the service and to offer information for women and their families.

## Staff engagement

- Senior managers told us they had engaged with staff through tea trolley learning rounds. This was a five-minute training session on subjects such as fresh eyes of cardiocograph (CTG) traces. 'Fresh eyes' is an approach where a colleague reviews fetal monitoring readings as an additional safety check to prevent complications from being missed. Another subject covered included mechanical induction (mechanical methods of induction promote cervical ripening and the onset of labour). Senior managers stated they could train around 40 staff in an hour and a half using this method of engagement.
- Managers provided staff with a weekly newsletter to share good news stories, learning and feedback. Managers also displayed information for staff on a good news board.
- The service had a closed social media group to share information with staff such as learning from incidents and new ways of working.

## Innovation, improvement and sustainability

- At the last inspection, the trust received a requirement notice in relation to following guidelines when monitoring the fetal heart with a cardiocograph (CTG). Senior managers told us fresh eyes was now on the mandatory training for staff. Fresh eyes' is an approach where a colleague reviews fetal monitoring readings as an additional safety check to prevent complications from being missed. Managers carried out monthly spot checks on fresh eyes and provided immediate feedback to staff where necessary. The compliance rate with fresh eyes was 93% for March 2019 and 89% for April 2019.
- Senior managers told us in response to recent incidents relating to MAU, staff had visited a maternity assessment unit at another trust to learn from them.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- The trust must ensure there is sufficient consultant presence in Maternity Assessment Unit (MAU).
- The trust must ensure there is clear escalation guidance for staff in MAU when medical staff are busy or unavailable.

### Action the hospital **SHOULD** take to improve

- The trust should ensure the MAU phone line is managed effectively, including timely triage and advice for women.

- The trust should ensure the physical environment of MAU provides privacy for assessments of women and staff handovers. Also, privacy for staff managing phone calls into MAU.
- The trust should ensure the abdominal pain guidance and pre-term labour guidance link with each other and include current NICE guidance and recommendations.
- The trust should ensure the requirement notice relating to equipment servicing from the previous inspection is met.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

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