University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Leicester Royal Infirmary

Requires Improvement 

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

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

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

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

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

The trust employs around 17,000 staff.

We carried out this short notice announced focused inspection to both the Maternity service and the Urgent and Emergency Care service.

We inspected urgent and emergency care at Leicester Royal Infirmary as part of our focused winter pressures inspection programme and to check improvements had been made since the last inspection in July 2022, after which we issued a warning notice under Section 29A of the Health and Social Care Act 2008. Our rating of the urgent and emergency care service did not change. We rated it as requires improvement although we recognised the trust had made some significant improvements, met the requirements of the warning notice, and improvements were ongoing in challenged times.

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

Our findings

Overall, we rated maternity services as requires improvement for safe and well-led.

How we carried out the inspection

Emergency and urgent care

The inspection was carried out unannounced and took place over 2 days on the 10 and 11 of January 2024.

In our preparation for the inspection, we reviewed information that we held and analysed data from other sources.

We spoke to senior and junior doctors, nurses and healthcare support workers, managers, ambulance crews and members of the professions allied to medicine. We also spoke to patients as well as relatives and carers. We reviewed records and attended meetings and staff handovers.

Following our inspection, we requested, and were provided with additional information.

Maternity

The inspection was carried out unannounced and took place over 2 days on the 10 and 11 of January 2024.

We inspected clinical areas in the service, including the delivery suite, antenatal and postnatal wards, the antenatal clinic, the maternity day assessment unit, community services, and triage. We spoke with 26 staff, including service leads, midwives, community midwives and medical staff.

We reviewed 7 sets of women; birthing persons records and 7 prescription charts and observed staff providing care and treatment to women. We spoke to 4 senior leaders following inspection and received a response to findings from the Chief Executive.

Urgent and emergency services

Requires Improvement 

- Using bank, agency and locum staff to supplement substantive staff, the service mostly had enough staff on duty to care for patients and keep them safe. Staff had training, experience and competence in key skills, understood how to protect patients from abuse, and managed safety well. The service generally controlled infection risk well.
- Although there were some gaps in some risk assessment, staff recognised risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- There was strong and committed leadership in the service. Leaders ran services with reliable data and systems, and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were caring and kind. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to continually improving services.

However:

- Despite measures to achieve significant improvements to access and flow in the department, some patients could not always access the service when they needed it because the department could still be crowded, and flow impeded. The service was not meeting many of the national standards or metrics around responsive care and treatment. This included patients sometimes having to wait on ambulances before going into the department. When they were in the department, many patients had to wait too long for treatment due to long waits at times for speciality assessments and waits for onward admission. However, readmissions rates were not high which is an indicator of quality care provided first time.
- Many medical staff were not up to date with their mandatory training, including for safeguarding.
- Risk assessments and subsequent treatments did not always take place in a timely manner including for sepsis. There was insufficient audit of the service to be able to closely monitor any lapses in care and treatment and insufficient time being provided to staff to undertake rigorous governance.

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not make sure everyone updated it.

Nursing staff mostly received and kept up to date with their latest mandatory training modules. Of the completion rates for the 8 mandatory training modules, 5 met the trust's target of 95% while 3 were below the target for updating mandatory training. These being fire, Infection Prevention and Control and cyber security which scored 92%, 90% and 89% respectively.

Urgent and emergency services

Medical staff were not keeping up to date with their latest mandatory training modules. All completion rates for all 8 training modules for medical staff were below 90%.

The mandatory training package was comprehensive and met the needs of patients and staff. It included training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. In addition to the trust's mandatory training syllabus there was additional training for staff joining the emergency department which was refreshed as necessary.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was overseen by the clinical educators in the department and there were computer systems and reporting to ensure nursing staff were monitored and aware of upcoming training requirements. We noted that while mandatory training was briefed in the morning medical staff handover there was not the level of oversight and administrative support for the doctors as there was for the nursing staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse and they knew how to apply it. However, the updating of safeguarding training for medical staff did not meet the trust's targets.

Nursing staff received training specific for their role on how to recognise and report abuse. The safeguarding training was appropriate for the different roles and seniority and the trust's target was met for all 5 safeguarding training modules to update staff around current guidance and principles.

Many medical staff did not complete the update training specific for their role on how to recognise and report abuse. While safeguarding training was appropriate for the different roles and seniority of medical staff, the trust's target was not met for all the 5 safeguarding training modules to update staff around current guidance and processes.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. When spoken with about safeguarding, staff, including medical staff were confident about recognising concerns or risks and how to report on these.

Safeguarding was an area staff referred to as being a strength of the department and we saw many posters and resources for staff, patients and carers including information about domestic violence and financial abuse.

Staff gave examples of safeguarding referrals some of which had required a high index of suspicion and thinking more strategically. There was a 'patients who self-discharge in the paediatric emergency medicine department children's guideline'. This meant those patients who fell into that category, required a review by a paediatric consultant in the 'following days' to ensure there were no risks or concerns emerging, including safeguarding, that needed follow-up. An experienced nurse who had recently joined the department told us the most impressive thing about the emergency department was the safeguarding of patients, particularly in respect of alcohol and substance abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust's electronic patient record system had flags for child protection information and was kept up to date by the safeguarding team.

Urgent and emergency services

Every child attending the department had a 'young person safety assessment' (YPSA) which was usually initiated at triage but had to be completed before discharge or transfer and included screening for issues such as bullying and drug use.

We checked a sample of records, and all had a YPSA except for one patient who had only been in the department for a short while. The daily 'nurse coordinator handover checklist' made sure all children who attended the department the previous day had been assessed.

Play specialists were well versed in safeguarding and how to identify concerns through their play and interactions with children.

We saw documents indicating that access to specialist independent domestic abuse advocates providing early safeguarding support and intervention had been reduced because of funding cuts outside of the trust. It was mentioned to us how this could result in delays providing appropriate support to people and additional work for trust staff who might not have the specialist skills.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well but we observed a few lapses in evidence-based practice around dress code and personal protective equipment among staff. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas, including those at height, were visibly clean and had suitable furnishings which were clean and well-maintained. The furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning and all the curtains appeared in good condition, were disposable, and dates showed they were regularly changed. The chairs in the patient waiting room area were in good condition, easy to maintain and keep clean. The waiting area was visibly clean and with minimal equipment and furnishings to keep people safe and support effective cleaning. We observed the waiting area being regularly cleaned and monitored for risks to patients and those with them. There were cleaning staff working throughout the rest of the department during our inspection. The areas we checked were clean and free from dust. In general, the department was tidy and well cared for.

The resuscitation area had bays with glass doors and internal curtains for privacy which allowed isolation and barrier nursing if necessary.

The children's ED was suitably equipped with washable toys and materials which were cleaned daily and after each patient. There were no soft toys in the department which otherwise can be an infection risk.

Staff mostly followed infection control principles including the use of personal protective equipment. However, we did observe some staff not adhering to the trust's dress code policy for infection prevention and control or not wearing face masks as was required at the time of our inspection due to a recognised heightened risk of COVID-19. Some staff either had face masks below their chin at times in a clinical setting or covering just their mouth and not their nose. In contravention of trust policy, we observed a member of clinical staff wearing nail varnish and with long nails. The department carried out dress code audits and this was scored for the last year at 100%. However, despite the high audit scores when we mentioned the issue to senior staff, they were already aware of some staff in the department not complying with the code and welcomed our information.

We noted a trust volunteer in the ED reception area offering face masks to patients or people with them in the waiting area and explaining why they were being asked to wear them.

Urgent and emergency services

We observed good adherence from staff to hand washing and infection control procedures. Staff were wearing gloves and aprons when it was required for their interactions with patients. Most washed their hands or used alcohol gel before and after any interactions with patients or when entering or leaving the department. However, the department carried out its own handwashing audits and we noted that the scores for 2023 only just met the target of 90% for 2 months and for 5 of the months they were below 80%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There was a regular deep cleaning schedule which incorporated the use of ultraviolet light.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe although frequent crowding meant it was not always able to support patients efficiently or effectively and sometimes required compromises. Staff were trained to use equipment and managed clinical waste well.

The design of the environment followed national guidance. This ED was one of the largest in England and had expanded in recent years to cope with crowding and capacity issues and the response to the COVID-19 pandemic.

The department had 5 separate entrances. There was a main walk-in entrance for adults and a separate walk-in entrance for children that led to the children's ED directly. An ambulance entrance served both adults and children and this led to an assessment area for adults while children went straight off to suitable area in the children's ED. Pre-alerted patients (those found to be critically unwell by the ambulance service and needing urgent medical treatment) entered through a separate entrance into a handover bay with doors both ends, overlooked from the staff base. From here patients could be quickly taken through to the resuscitation or other areas.

The resuscitation area was spacious and suitably equipped. There were 12 bays with sliding glass doors and an internal privacy curtain making them suited for barrier nursing. Two of the bays at the children's ED end of the resuscitation area were equipped for children and 2 more could have suitable paediatric equipment moved into them. The resuscitation area was considered as generally large enough to manage demand of critically unwell patients.

The cubicles in the majors and minors areas were suitably equipped and in the majors area, again many had sliding glass doors and an internal privacy curtain.

Mental health rooms met safety guidelines. In the children's department one cubicle had shutters that could be drawn across to secure medical equipment to make the environment more suitable for patients at risk of self-harming.

The children's department was suitably decorated and equipped with toys and materials. There was a multisensory unit and an adolescent area with a TV and graffiti wall. However, the area became crowded when the department got busy, and this presented a risk that children could not always be cared for in a suitable setting.

The trust had made considerable efforts to expand the size of the department to accommodate the increasing numbers of patients attending. There were innovative approaches to holding patients at different times in their pathway through the department and because of this it was rare that patients had to be accommodated in corridors or other areas. We noted these new expansion areas were built to a high standard and staff praised the work done by the estates department in enabling this.

Urgent and emergency services

These recent changes included the construction of a Patient On Ambulance (POA) Escalation Pod co-located at the back of the main emergency department and connected by purpose-built walkways. This area was in a group of converted temporary buildings designed to be used on a more permanent basis when the need to release patients from waiting on ambulances became more urgent. The area was safely set up with safety and other equipment, trolley beds, curtained cubicles, and was always staffed. The patients we met on the unit said they felt safe and well looked after.

Nevertheless, the department continued to be crowded due to flow outwards for patients into equally busy medical and surgical departments, and this issue was noted as a significant patient safety issue on the department's risk register.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were checked twice a day on the 2 shifts, but these were to be amalgamated into a single check to be once a day. There was an additional monthly check by a matron. We noted that the checking of the emergency equipment was itself audited and that in one location the resuscitation trolley had failed the audit. As a result, the matron checks in that area had been increased.

Other specialist equipment such as grab boxes for hypoglycaemia, sepsis, and difficulty in breathing, and automatic chest compression equipment had their own checklists which were noted as completed. In the children's department there were checklists for all rooms and cubicles in the department. We made sample checks, and they were mostly complete with only minor omissions for the office and the nurse station.

The service had suitable facilities to meet the needs of patients' families. There were rooms dedicated to patient's relatives and two of these rooms were located next to the resuscitation bays that were used for those adults and children with a poor prognosis.

The service had enough suitable equipment to help them to safely care for patients. The department was well equipped and had plenty of stocks of routine and specialist equipment and consumables were held within the department.

We observed resuscitation bays being cleaned and reequipped after every patient with the use of protocols and checklists. There were well organised stock bays and shelving for stocks of equipment such as infusion devices, chest compression devices and ventilators, all of which were in date. All the medical devices we checked had labels indicating their next service date and all were within that date. We noted that piped medical air outlets had been capped off in the bays we inspected in line with a recent Medical and Healthcare Products Agency safety alert.

There were clean utility rooms, one of which held stocks of blood and blood derived products. There were point of care testing machines in the department as well as a pathology 'hot laboratory' to rapidly process and report on patient's tests. There were 24-hour computed tomography and projectional X-ray rooms immediately adjacent to the ED. Magnetic Resonance Imaging (MRI) scanning was available 8am to 8pm and then on-call thorough the night. When asked, staff had no concerns about the quality or capacity of the imaging service.

The only issue mentioned to us was that staff did not have equipment to get doors open when they were concerned about the safety of patients in the lavatories. We were told that this had been requested and escalated but nothing done.

Staff disposed of clinical waste safely. Clinical and other waste, including sharps were disposed of in suitable waste bins and we did not see any of these overflowing.

Urgent and emergency services

Assessing and responding to patient risk

Staff did not always complete risk assessments in a timely manner for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The early warning scoring system used by the ED was completed through the recording of results and observations on the electronic patient records. Compliance with the system was audited and results demonstrated that adherence was largely satisfactory.

Patients were also allocated a 'dynamic priority score' as part of the Visual Assessment Clinician (VAC) process which is described fully, later in the report.

There was an ambulance assessment unit staffed by ambulance crews provided by an independent company but under the management and clinical governance of the trust. To prevent them remaining on an ambulance, some patients were cared for here before they were taken into the main area of the ED. There were effective standard operating procedures for their assessment and the identification of any deteriorating patients.

When patients were queuing in ambulances, clinicians from elsewhere in the trust were asked to provide additional medical support to the ED. This was to enable members of the ED team to carry out assessments of the patients in the ambulances when the waits were prolonged. Patients waiting over 15 minutes on the back of an ambulance to come into the ED were required to have a clinical assessment, and a dynamic priority score review.

The trust policy was for children not to remain on an ambulance or in an ambulance assessment area but to be taken straight through to the children's ED. Trust documents stated the increase in children attending the department was causing crowding and delays to treatment presenting a risk to patients. We saw how 15 patients per hour, which was considered a high attendance rate in 2016, was now the average and on occasions the rate was 25 per hour. While all children were visually assessed by a clinician within 15 minutes of arrival, the department's risk register noted that further delays in diagnosis and treatment had a potential for harm as children are at greater risk than adults for early deterioration.

The trust had responded in a variety of ways including additional agency staff being used, ensuring there was constant visual oversight of the waiting room and placing an advanced clinical practitioner at the children's front door. Staff were brought in from the adult department at peak times and band 7 nurses and matrons had had their management time reduced to provide extra clinical resources. However, the recruitment of children's nurses from overseas was coming to fruition as they came out of their preceptorship period and staff were positive about the experience and skills they were bringing to the department.

Staff knew about but did not always deal with any specific risk issues with concerns about sepsis. During the inspection, staff raised concerns with us that they recognised the department was failing to meet sepsis standards. We escalated this and the trust informed us that in early 2023 they had identified through internal audit and external mortality data that there was a trust wide problem with relative risk for septicaemia, other than in maternity, flagging as "high". They provided information on how this had been addressed and that there had been and continued to be, a fall in relative risk.

Urgent and emergency services

We requested further information and saw that within the ED there had been an increase in adult patients receiving their antibiotics for sepsis within 1 hour (as guidance recommends) through 2023 but a recent downturn in the autumn. However, these were low figures with no more than two-thirds of patients receiving timely care in a typical month. Significant numbers of patients received their antibiotics between 1 and 3 hours and many patients received their antibiotics more than 3 hours later. This represented a serious risk to those patients developing sepsis.

For children in the ED, data showed the situation was similar with again only two-thirds of patients receiving antibiotics within the one-hour target. Within the data there were some significant variations with one month recording 100% compliance and another month only 25%. However, the number of paediatric patients was significantly lower than adult patients, so variation was more likely. Unlike for adults, there were no child patients over the 2 years of the data we reviewed that had their antibiotics delayed by more than 3 hours. The department had also introduced oversight of sepsis assessments through the nurse coordinator handover checklist.

Within the ED there was a focus on sepsis management with the involvement of a dedicated ED sepsis group, a reemphasis on relevant training including senior decision makers and the reintroduction of sepsis champions. The trust believed that these changes were having a positive effect and that this was starting to be seen in the data.

Given the extended length of stay for adult patients in the ED, changes had been made to the observations usually carried out in such a department. There was enhanced observation and monitoring of skin integrity including for those patients onboard ambulances. Small pressure mattresses that could be used on ambulance trolleys were available and there were procedures to turn patients to help preserve skin integrity. Patients staying longer than 14 hours in the department were given a venous thromboembolism assessment and if necessary, a dose of a suitable prophylactic anticoagulant to help prevent blood clots developing.

The service had 24-hour access to mental health liaison and specialist mental health support. This service was provided by another NHS trust, but the mental health staff were co-located on the hospital site. We requested figures about referrals, and patients were seen in an average of 50 minutes with them being seen within the target 63% of the time. Children and Adolescent Mental Health Services were available from 8am to 8pm each day.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. There was a mental health matron for the trust who worked across both adults and children. This was a new role introduced 12 months previously and they supervised a mental health nurse and an approved mental health practitioner. This team supported staff and liaised with staff at the local mental health NHS trust. They attended child safeguarding meetings for children and vulnerable adults and through this, supported frequent attenders to the department.

Staff told us that they thought the role was valued and that it made a difference to patients and the staff. The mental health practitioners provided ED staff with additional training in the Mental Health Act and associated subjects, such as alcoholism and domestic violence.

We were told there were very good relationships with the security team, and they reviewed and supported those patients who were on one-to-one observation, and the staff looking after the patient.

Enhanced care observation nurses supported patients who needed higher levels of observation including one to one care. They had skills to distract patients with learning disabilities, dementia, or mental health issues. During our inspection, a patient became very distressed and disruptive, and we saw good support provided to deescalate their behaviour and keep them and those around them safe.

Security staff and nurses in the department were trained in control and restraint and less risky patients could be overseen by healthcare support workers. We noted through patients' notes how the security staff were very aware of mental capacity and frequently requested that a patient be reassessed if they were concerned that restraint was no longer justified.

If a patient in the department attempted to self-harm, we saw that, as well as responding to the situation, a nurse from the mental health liaison team reviewed the patient's notes to see whether the risk might have been identified beforehand. There were posters with contact details and QR codes for patients to access mental health resources and self-refer.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We attended nursing and medical shift handovers, and the relevant information was exchanged about the department with clinical leaders. Because the department was so large, this was then cascaded down through huddles for individual areas where information on individual patients was shared. Following the start of a shift, there was a walkaround by senior staff to offer support and pick up any issues raised in the local area huddles. This process was valued by the staff and the leadership.

Nurse staffing

Staffing levels for nurses had much improved. The service mostly had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, this was always achieved by bringing in bank and agency staff. Nevertheless, crowding in the service put excessive pressure on nursing staff. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service mostly had enough nursing and support staff to keep patients safe, although this was always achieved by bringing in bank and agency staff. This posed some risk from a lack of experience, knowledge of the department, and recognised skills. All staff told us staffing was one of the department's biggest challenges, but we did note substantial improvement since our last inspection. The 2022 staff survey results for the ED were very negative in the response to the statement "Enough staff at organisation to do my job properly".

However, senior nurses told us staffing had improved enormously. We were told new recruitment schemes such as the introduction of overseas nurses, recruitment days and more exit interviews were having a positive effect. It was noted some reasons people left could have could have been dealt with so there was a project using computer surveys and suggestion boxes to capture concerns before people left. There were healthcare assistant and band 5 nurse focus groups every 6 weeks to support retention by identifying concerns.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance and the need of the department. There was clear guidance as to the skills and qualifications needed to safely staff the different areas of the ED and this was used to plan rotas and identify any risks due to gaps in staffing. Capacity for individual areas of the department was varied based on maintaining the safety of the patients in the respective place.

The number of nurses and healthcare assistants largely matched the planned numbers. In the adults area of the department, figures for the 3 months prior to the inspection showed that fill rates for registered nursing staff were around 93% for day shifts and 97% for night shifts. For healthcare assistants the rates averaged around 90% and 88%, between day and night shifts but with more spread.

Urgent and emergency services

For children, fill rates for registered nursing staff were around 90% for day shifts and between 90% and 97% for night shifts. For healthcare assistants the rates averaged around 86%. The department's risk register noted that at times it was difficult to meet the standard of 2 registered children's nurses on each shift as required by the Royal College of Paediatric and Child Health guidance. It was further noted that it was felt that the number of attendances meant that 2 registered children's nurses were not always enough to cover the workload safely.

Staff were brought in from the adult department at peak times and band 7 nurses and matrons had had their management time reduced to provide extra clinical resources. However, the recruitment of overseas nurses was coming to fruition as they came out of their preceptorship period and staff were positive about the experience and skills they were bringing to the department.

Further concerns were that because the children's ED was part of a management group that predominately dealt with adults, it was difficult to pull children's nurses from other parts of the trust. Staff were sometimes tied up caring for acutely ill children waiting for beds to be available at specialist children's hospitals.

On the second day of our inspection, it was noted at the senior nursing huddle at 8.30am that the department was staffed to the required number.

The service had high vacancy rates of around 10% for nursing staff in the ED. In the children's ED the department's risk register stated that the vacancy rate was 36%, and the registered children's nurse/registered nurse split was 68%/32%. However, the service had reducing turnover rates for nursing staff.

The service had higher than average sickness rates. For registered staff in the adults service, sickness rates were slightly above the NHS average and for healthcare assistants they were significantly higher. For staff in the children's area of the department sickness rates were significantly higher that the NHS average. As is typical across NHS trusts in England, the main cause was listed as 'anxiety/stress/depression' closely followed by colds and flu over the winter months.

The service had high rates of bank and agency nurses used to supplement nurse staffing numbers. For example, agency staff could not give intravenous drugs or fluids which put additional work on the other staff and was the cause of delays, particularly over the winter.

Managers said they would have preferred to limit their use of bank and agency staff but at least most of the staff used were familiar with the service. Agency rates for registered adult staff for the 3 months prior to our inspection were between 10% and 20%, and for the children's part of the department at least 30% and sometimes as high as 50%. Some staff commented that some shifts were "agency heavy" and while most agency staff were regulars, others did not have the same level of confidence and competence. An example given was that agency workers could not give intravenous infusions which put additional work on the other staff and was the cause of delay to treatment, including antibiotics for sepsis, particularly over the winter.

Managers made sure all bank and agency staff had a full induction and understood the service. There were systems to ensure all agency staff had their skills and qualifications checked and updated and that they had received an induction in the previous 3 months. In the children's department, checking the competence and induction status of agency staff was part of the nurse coordinator handover checklist.

There was a large cohort of overseas nurses working in the department. Those we met said they had been given a warm welcome and supported with living arrangements, conversion exams, and practical support. Each had a mentor when they were new and said nothing was too much trouble for any of the staff who supported them. There were networks established in the wider trust to support new nurses, including newly qualified nurses. Some of the mentoring was informal particularly if a new member of staff was felt to be struggling.

Medical staffing

Using locum doctors to fill gaps, the service mostly secured enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, crowding in the service put excessive pressure on medical staff. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe although there were significant vacancies at consultant, middle grade, and junior level in the ED. The department's risk register noted this was because of a national shortage of trainees and consultants in the speciality. This was in part due to a variety of factors including juniors not selecting the speciality, emigration and early retirement, or reduction of working hours.

The NHS England East Midlands Local Education and Training Board had recognised middle grade shortages as a regional workforce problem and had set up projects to attract and retain specialist trainees. These were having some effect.

The increasing numbers of patients had an impact with the funded consultant establishment not meeting demand. Initiatives to accommodate more patients in the department, while addressing the needs of the patients, had not been supplemented by the recruitment of additional staff.

Work was underway to address the shortages through a recruitment and retention action plan which included overseas recruitment of staff grade doctors.

The medical staff usually matched the planned number with the use of locum doctors. The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical rotas had been optimised to match staffing levels with peaks in demand and long-term locum medical staff had been employed to fill gaps in rotas. Nevertheless, the service had high rates of locum staff. Managers could access locums when they needed additional medical staff. These were also supplemented by employing non-training core trainee grade doctors as locums.

Vacancy rates for medical staff in the ED department had improved since our last inspection. The rate for consultant staff was 10% and the rate for staff grades 42%, although this latter group only represented 10% of non-trainee staff. Most medical staff in the department were trainee grades and the vacancy rate for them was 5%.

Sickness rates for medical staff were typical of the NHS average.

The service always had an emergency medicine consultant present or on call. Shift staffing was 5 emergency consultants on duty between 8am and 1pm and 7 emergency consultants between 1pm and 6pm. There was 1 medical consultant in the team from 8am to 11pm to cover those medical patients waiting on beds although this was covered at the time of the inspection by an internal locum. No agency locums were used.

Urgent and emergency services

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, there was a dual electronic and paper-based system in operation which led to inefficiencies.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. There was a hybrid system used where nursing records, including those observations that contributed to scoring systems, were recorded electronically and medical records were on paper. We were told that this led to duplication of records. Staff did not express safety concerns but most commented that there was a need and desire to phase out paper because of inefficiencies. There was a plan to move the ED to entirely electronic records, but some staff said the progress was slow.

We noted some incident reports where the completeness and quality of record keeping had been noted as a cause, although none of the records we reviewed were incomplete.

We reviewed 5 sets of notes in adult majors and all mandatory assessments were completed and recorded on the electronic patient record system as were all hourly patient safety checks and other tasks such as re-positioning.

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. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There was a pharmacy in-reach team in the department 8am to 8pm weekdays and 8am to 7pm on weekends. However, this service was not always available because of staffing problems in the trust's pharmacy department which reflected the national situation. The department had their own pharmacy technician who worked days. This service had proved valuable and effective and so 2 more departmental pharmacy technicians were being recruited.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. We noted that medicines, including controlled drugs were appropriately stored and secured. Drug cupboards were well organised and stocked and protected by electronic code pads. There had been an initiative to decide the stock levels of drugs needed to reduce waste while assuring availability. Drugs cupboards were stocked by the main pharmacy but overseen by the department.

The department held a stock of the most commonly prescribed medicines to reduce length of stay by having 'to take out' medicines readily available for patients who were being discharged.

Staff learned from safety alerts and incidents to improve practice. Medicines errors were reported through the trust's incident reporting system, and we saw examples that demonstrated this. The trust had a system to manage safety alerts including for medicines and medical devices.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

We were told of and observed in practice the 'get it on time' initiative to ensure patients got time critical medicines. Time critical medicines (TCMs) are those medicines for people with conditions such as diabetes, epilepsy and Parkinsons

disease where missing a dose seriously affects their health. This was part of a 3-year Royal College of Emergency Medicine improvement project. We observed a slide show on the display screens in waiting areas to ask patients to alert staff if they were on TCMs. There were yellow stickers on notes to remind staff to be aware of TCMs. The outcomes of timely administration were audited at a monthly meeting between the ED and the pharmacy department. These audits had already demonstrated improvements in patient's conditions, and it was hoped it could lead to a reduction in the patient's length of stay.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. All staff when asked knew how to report incidents and could usually give examples of incidents that they had reported such as falls, violence and aggression or absconding when vulnerable patients left the hospital site to smoke.

Managers shared learning with their staff about never events that happened in the department or elsewhere. This happened through the trust's overall procedures.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. When asked, staff could describe the duty of candour and give examples. We requested the 2 most recent examples of serious incident reports when patients had come to harm in the department. The requirement for consideration of the duty of candour was embedded as part of the process as was the involvement of the patient and their family.

Staff received feedback from investigations of incidents, both internal and external to the service. There was evidence of how changes had been made because of feedback. Managers investigated incidents thoroughly. Incidents were discussed in the monthly governance report. There was a monthly email about lessons learned from incidents. When asked about the current hot topic staff told us it was missing observations, particularly recording patients' blood pressure and weight in the children's ED.

Is the service responsive?

Requires Improvement 

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Facilities and premises had been much improved to increase bed capacity and were mostly appropriate for the services being delivered. There were still times when patients had to be held on the back of ambulances, but there was clear recognition by the trust of the need to always keep this in clear focus. Staff told us that the recruitment of overseas nurses had brought lots of experience and cultural diversity into the department that benefited the understanding of local people's needs.

Urgent and emergency services

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust complied fully with the 2019 NHS England 'delivering same sex accommodation' requirement. The issues raised in our previous report around this had been fully addressed.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week, for patients with mental health problems, learning disabilities and dementia. This service was provided by another local NHS trust, but the staff were located on the Leicester Royal Infirmary hospital site. We requested figures about referrals, and patients were seen in an average of 50 minutes with them being seen within the target 63% of the time. Child and adolescent mental health services were available from 8am to 8pm each day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Enhanced care observation nurses supported patients who needed higher levels of observation including one to one care. They had skills to distract patients where this helped patients with learning disabilities, dementia, or mental health issues.

We noted there was an initiative to improve support for people with autism and we saw posters in the reception area asking the public's views on how best to support people with autism.

Wards were designed to meet the needs of patients living with dementia. There was an area in the department where frail and elderly patients including those with dementia were cared for so their needs could be better met. Aside from being overseen by gerontologists and specialist nurses from the frailty emergency team, there was other support for vulnerable patients such as from a "meaningful activities team" that gave support to elderly patients who were staying in the department for a long time.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff always had access to the trust's interpretation service and a 'language line'.

Patients were given a choice of food and drink, although this did not always meet their cultural and religious preferences. Because patients were frequently staying the ED far beyond the 4-hour standard, the department had arranged for them to be provided with meals. Hot food was available, usually a jacket potato, and cold food, such as sandwiches. However, staff told us that the default sandwich that was provided was ham which was unsuitable for many of their patients and did not reflect the wide choice of culturally suitable food available in the rest of the trust. We were also told that there were no facilities to heat food, and this had to be done in the ambulatory medical unit.

Staff had access to communication aids to help patients become partners in their care and treatment. The children's ED had 3 play specialists providing a service from 7.30am to 10pm whose skills were valuable in helping staff communicate with young children.

Urgent and emergency services

Access and flow

Although significant improvements had been made, capacity pressures, rising demand, and crowding meant some patients were not able to access the service when they needed it. As a result, they did not always receive the right care on time. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards and worse than regional and national averages.

Context and demand

The ED at the Leicester Royal Infirmary is among the largest in England. It is the only ED in the county of Leicestershire, and it often received patients from other areas when smaller EDs were diverting patients due to capacity problems. There were between 19,100 and 21,600 type 1 (emergency) A&E attendances each month at the trust between May and October 2023 (the published data at the time of our inspection). This is around 680 patients a day. There had been a slight increase in attendance in the last two years from November 2021, although not significant.

The demand on the department was mostly always higher than its planned capacity due to patients being held in the department for too long waiting for other services. The department was often chronically crowded resulting in increasing care needs. This was primarily due to increased lengths of stay for patients in the ED after admission requests or referrals to specialties meaning beds were not becoming free as planned and designed. These patients required ongoing care and treatment from the ED team. This was in addition to the input provided by the inpatient specialists who following acceptance of their patients were required to attend the ED to manage them.

The department's risk register noted crowding and longer stays in emergency departments was associated with increased risk of mortality and morbidity which was a nationally recognised risk.

The reasons for increases in numbers of patients attending ED were varied and changeable. However, like most EDs in England, this came from a mixture of patients often not being in the right place to seek help. This included those unable or not attempting to get an appointment with their GP, rising demand for mental health services, which were already stretched in their service capacity, and problems associated with community care and support for people living with deprivation and homelessness.

Managers monitored waiting times but could not make sure patients could access emergency services when needed and receive treatment within agreed timeframes and national targets.

Pathways through the department

Patients were remaining too long in the department. The trust's median total time in A&E was consistently higher than the England average from October 2021 to September 2023 (the latest validated published data at the time of our inspection). The waiting time improved from January 2023 onwards following improved facilities in the department but remained above (worse than) the England average. In September 2023, the trust median time was 3 hours 34 minutes compared with to the England average of 2 hours 58 minutes.

The department was not meeting the waiting time standard. In the two years from November 2021 to October 2023, the percentage of patients being admitted, transferred or discharged within four hours was generally slightly worse than the England average although similar to the average for the Midlands. In October 2023, the trust's performance was 51.2% compared to the England average of 55.9% and Midlands average of 52.4%. The NHS constitutional standard for the

four-hour decision was for 95% of patients to be seen, but this had been reduced as a temporary measure to 76% while services recovered from the pandemic. The trust had not achieved this standard, but at the time of writing (March 2024) had improved somewhat to 55.3% for type 1 patients. However, this was still significantly away from the standard which was designed for optimal care for patients.

Further evidence of the effects of crowding were the number of patients waiting over 12 hours in any one month from the decision to admit to admission (sometimes described as 12-hour trolley waits). December 2022 was the worst month on record for England's A&E departments and no different for Leicester Royal Infirmary. The peak in 2022 was 1,299 patients waiting in December for more than 12 hours. However, in October 2023 there were 1,330 patients waiting compared with 981 a year earlier. The number had increased since November 2021 from around 600 to over 1,300. However, at the time of writing (March 2023) the number had decreased to 982.

Seriously ill patients, including children, who had likely been pre alerted by the ambulance service arrived through a separate entrance into a handover bay. From here they would usually go into the 12 bedded resuscitation area or if that level was not needed into another area.

Adult walk-in patients arrived at the ED at the main front entrance and were directed to the waiting room known as 'Walk In Assessment' (WIA). Children had a separate entrance at the rear of the building that led directly into the children's ED.

Patients arriving in the WIA area were booked in by the receptionist and sent on to a visual assessment clinician (a doctor or a nurse) who would ask questions and visually assess the patient. They would then possibly ask the patient to attend other services, specialties or areas (such as the ambulatory assessment area or a GP referral), or more usually direct them to be seated for ED assessment and treatment. From the seating area, which had a capacity of 55 patients, patients would then be called to one of the 8 assessment rooms for more formal nurse assessment. The target for assessment was 15 minutes and time spent in the area 30 minutes.

Ambulatory patients were seated in the ambulatory seating area in one of 48 chairs assigned to this purpose and were treated in the ambulatory treatment area that could accommodate 14 patients. Patients treated here were often sent back to wait in the ambulatory seating area between investigations and elements of their treatment.

Patients brought by ambulance, both adults and children, arrived in the ambulance bay. Children went directly to the children's department and adults to the ambulance assessment area. The area undertook rapid assessment, streaming and treatment of patients. The target for assessment was 15 minutes and time spent in the area 30 minutes. It had capacity for 10 patients.

Should the ambulance assessment area be under capacity pressure, a temporary area known as the patients-on-ambulance escalation pod was opened. The pod had capacity for 14 patients on trolleys and 2 seating. We saw evidence that the introduction of the pod in January 2023 had significantly improved the average wait times for triage. However, this still showed variation over the year as while the 15-minute target was largely met through the summer months, the winter of 2022/23 and 2023/24 showed deterioration in times to around 30 minutes. However, this was a noted significant improvement from data in our previous report.

From these areas, patients were streamed on to either major or minor areas dependent on their treatment needs. The majors area was split into red and blue sections to enable infection control streaming to be carried out in response to COVID-19 or other infectious diseases or conditions should the need arise. Blue majors could accommodate 16 patients and red majors, 32.

Other areas of the ED to which patients might be streamed included the GP led 'minor injuries and minor illnesses' (MIaMI) unit. There was also a 10 bedded transfer hub that accommodated patients waiting to be transferred to beds elsewhere at the Leicester Royal Infirmary. Patients were also transferred to the Glenfield Hospital which had specialist units for cardiac and respiratory treatment.

Triage and assessment

The visual assessment clinician process had been introduced as a method of managing and assuring safety in the main waiting area of the department. This was judged as the highest risk area as many patients self-presented without having had previous contact with healthcare staff.

Around 2 years ago, from October 2021, the trust was worse than the England average for median time to treatment. However, this improved in around April 2022 and had dipped above and below since but was not a significant outlier.

Patients arrived in the walk-in area usually as a self-presentation. However, they also came from referral by another provider such as a GP, NHS 111, or from an ambulance as a patient having been assessed as suitable for this area in the ambulance assessment area.

The patient was booked in by reception staff and reviewed as soon as possible by a VAC practitioner who assigned a 'dynamic priority score' dependent on the patient's risk and urgency. This was usually done by a nurse and was known as the 'primary nurse assessment.' However, there were times when the role was taken by a doctor. The service considered this met the requirements for initial assessment within 15 minutes and this was largely met with 85-92% of patients being seen within the target time.

If the practitioner judged it necessary, the patient would receive further streaming to immediate assessment. This allowed higher-risk or the sickest patients to be directly admitted into the department and for other patients to be redirected to other non-emergency services as deemed safe for them.

Patients not immediately seen or diverted would have a nurse assessment carried out, known as a 'secondary nurse assessment'. The service's experience was that most ED walk-in presentations were dealt with through the initial visual assessment clinicians review, and this resulted in safe and efficient triage. The VAC team were also able to speed the patient's journey through the department by pre-empting the ordering of tests such as ECGs and X-rays.

We observed the system at several times during the inspection and we noted that it was operated effectively and proved an effective response to the warning notice served following the last inspection. We also noted the system was adapted to increase the number of practitioners in line with demand and by ensuring senior medical staff were present. It was often the case that the 'emergency physician in charge' (EPIC doctor) was present to provide the most authoritative decision-making right at the front door. This included acting according to the demand in the department, and where the pressures were.

We also observed how an additional level of safety was provided by nurses overhearing the patient's conversation with the receptionist and the nurse's conversation by a doctor. To that end, and for safety of patients, patients were observed by clinicians when entering the department, when queuing, and when sitting.

There was also the opportunity for staff to rapidly ask for a colleague's opinion. On one occasion we saw a nurse who had carried out an electrocardiogram (ECG) as part of secondary nurse assessment ask a consultant carrying out the VAC role to review an ECG strip as they were unsure what it indicated. As a result, the patient was immediately taken into the department's resuscitation area. We also saw a doctor move a deteriorating patient from the waiting area and straight into a treatment area.

All seats in the waiting room could be seen from the reception desk. Overall, the system was efficient and effective provided there was manageable patient capacity in the department.

Further safety and welfare observation was carried out by walkarounds by healthcare assistants and ambulance technicians who were seen observing and speaking to patients.

We were told an identified risk was with assessed patients sitting at the end of the waiting area waiting to go to red majors with their backs to the desk. These patients might be potentially the sickest patients in the area but with without face-to-face oversight. Everyone knew of the issue and there were plans to reconfigure the area, but it represented a risk at the time of our inspection. However, the area was always busy and occupied by patients and staff and there had been no incidents we were aware of about harm coming to patients in this area.

Too many patients were leaving before being seen. The number of patients leaving A&E before being seen was an indicator of problems with access and flow. At Leicester Royal Infirmary, the number was consistently somewhat higher than the England and regional averages across October 2021 to September 2023. From October 2022 onwards there was a considerable deterioration in the trust's data in this metric. By July 2023, the percentage of patients leaving before being seen was 30.4%, the highest proportion for any trust in England that month. However, the percentage reduced to 10.6% in September although this remained firmly above the England and regional average.

Reattendance rates can be a measure of patients not receiving fully effective treatment and needing to come back. However, at Leicester Royal Infirmary, the rate of reattendance was much the same as the England average and generally slightly better.

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Patients on ambulances

Waiting times on ambulances had significantly improved due to the efforts by the trust to tackle this problem. Before January 2023, the proportion of patients taking more than 60 minutes to handover was consistently above 24% and as high as almost 40% at times. From January to September 2023, it was significantly improved with the opening of new facilities and fell below 13% consistently and had been zero at times. However, October 2023 showed a rise and increase to 20% and numbers were on the increase as winter approached.

When the department became full and delays started to increase, adult patients could be held on ambulances because they could not be received into the department. These patients, while the responsibility of the ED, were cared for by ambulance crews.

Adult patients who were awaiting handover in ambulances were assessed using an ED ambulance patient safety checklist. All patients waiting longer than 15 minutes on an ambulance were required to have a clinical assessment and

a dynamic priority score assigned. There was a protocol for assessing and caring for the patients. In the first hour they were assessed for pain, continence, and pressure area concerns. Positioning and the giving of pain relief was carried out as required. In the second hour any critical medicines were assessed, and refreshments provided if possible. Regardless of the amount of crowding in the department, we were told by staff and the ambulance personnel we met that no patient would be held on an ambulance if they needed urgent or immediate medical attention in the department and they would be rapidly transferred.

Departmental policy was that children were not to be cared for on ambulances and we were told by staff this had never happened.

Managers and staff started planning each patient's discharge as early as possible. Staff supported patients when they were referred or transferred between services.

Outflow

Significant work was still needed to improve the movement out of patients from the department to specialist care in the rest of the hospital. The inability at times to move patients out of the ED into the rest of the hospital was a key factor in the pressure on the department. The adult emergency department escalation plan noted how the plan was most often triggered due to patients not able to be moved to where they needed to go next. The trust worked hard to improve the situation, but it was clear that while the various initiatives and processes had positive effects, the situation was far from resolved.

The trust had introduced inter-speciality professional standards to require the rest of the hospital specialties to support admission to their service from the ED. This had been implemented in July 2022 and required the trust specialties to a accept a patient for review within 5 minutes and to decide to admit or not within 30 minutes, thus closing the referral. Should a review need to be carried out in the ED, the closure target was 60 minutes. There was also the requirement that if the patient subsequently needed referral to another speciality, then this should be done directly, not by sending them back to the ED. Some specialties, such as occupational therapy and frailty had extended targets because of the length of time their reviews took.

Once patients were reviewed and accepted by the speciality they were under the care of that speciality even if they remained in the ED.

Performance was being monitored by the trust who were able to provide data and commentary for the 3 months prior to our inspections and comparing it with 12 months previously. The data provided was not fully complete as some out of hour referrals were done through on-call arrangements when the speciality doctor was not resident overnight. There were some technical issues with the operation and monitoring of the e-referral system, but there was evidence of a noted improvement, nonetheless.

However, the trust stated most referrals did not meet the standard for seeing the patient in the time requested and remained non-compliant with the professional standards agreed for safe and effective care. We understood there were some issues with data being reported incorrectly as well as some specialties not closing requests properly on the computer system that might have caused this. However, the trust's own commentary noted the department was "still far from achieving" the targets to accept and close referrals. Significant work was still needed to improve the outflow from the ED. The trust provided examples of identified issues and both proposed and ongoing solutions and mitigations.

Further information showed staffing levels in certain specialties were possibly the root cause of their poor performance in supporting the ED. For example, while ear, nose and throat always accepted patients promptly, and had improved their time to close, the workload for their junior doctors was such that they could not improve further. The trust had also identified plastics, orthopaedics, the GP assessment unit, and the cardiac and respiratory clinical decision units as being challenged.

The inter-speciality professional standards identified escalation mechanisms to senior staff within the specialties to ensure standards were being met. Oversight was through the daily tactical meetings. There was also a mechanism for the senior operational medical leader or senior manager on call to act as a final arbiter. Despite this the performance was falling far short of the required standard and put the department under considerable additional pressure. This presented a risk to patient's timely and effective treatment.

The trust was continuing to work on the development of pathways between the ED and specialties.

Managers monitored patient transfers and followed national standards where possible. Managers endeavoured to keep patient moves between areas to a minimum. Because of the different specialist areas of this large department, and the need to accommodate patients in holding areas prior to them being admitted or transferred, patients could be frequently moved from one area to another. However, this was usually in their best interests as the area to which they moved would facilitate either their treatment or comfort as well as to release resources to treat other patients.

Oversight of capacity and flow

All staff in the department had a clear view of the current state of the department displayed on large computer monitors in every area. Senior staff and managers constantly used this information to make decisions. Since our last inspection, the trust had developed systems and processes to better monitor and react to stresses on the department that resulted in crowding and poor patient flow.

There was a comprehensive information system that monitored the capacity within the department. This was constantly used by managers at a departmental, trust (tactical) and system (health economy) level. The trust also had access to information from the NHS ambulance service about its, and other hospital's statuses so that upcoming demand could be predicted to an extent.

At a departmental level, senior medical, nursing, and managerial staff were always aware of the capacity within the department, and they managed flow and risk by making decisions about which areas to open or close, where to allocate staff and where to place patients.

This was usually done through meetings, often described as 'huddles' that took place at times when key personnel handed over responsibilities when leaving their shift. They also happened to react to changing circumstances at the discretion of the lead nurse or doctor. Examples we saw included a regular huddle where the emergency physician in charge (EPIC) was leading a walkaround of the department to discuss acuity and capacity. In another example, 3 pre-alerts had been received from the ambulance service and the resuscitation area was already busy. A huddle took place to decide which patients could be transferred to the majors area to accommodate the patients on their way and still maintain the requirement to have free cubicles for other emergencies. At the start of day shift we observed a senior nursing team huddle where flow was discussed in detail with the senior nurse stressing the mechanisms to be used to relieve the pressure on the department through rapid flow.

Urgent and emergency services

Tactical oversight was through the mechanism of videoconferences that involved those departments that were involved moving patients along their journey through the hospital. These meetings were scheduled throughout the day and took place dependent on the pressure the hospital was under.

We attended 2 of these meetings and noted that they were well run to a standard agenda with defined systems and processes. We attended a 1pm meeting during which the trust was starting to prepare for the night and so medical and nurse staffing was discussed. It was noted medical staffing in the ED was fine and nurse staff gaps would be covered using agency.

The occupancy and acuity of the ED was assessed, and it was noted the department was becoming busier as the patients self-presenting were quite sick, the ambulance service was busy, and patients were starting to be cared for on ambulances. It was agreed the assessment pod would likely need to open as the ambulance service currently had 30 patients waiting for an ambulance to attend and this was known to be a good predictor of demand on the ED. The statuses of other local EDs were noted in case these resulted in patients being diverted to the Leicester Royal Infirmary.

We observed a second tactical flow meeting at 9am. This reviewed the state overnight and developed plans for the day ahead. The number and speciality of patients waiting was reviewed and requests made for clinicians to review lists to see which patients might be transferred from the ED into ward beds. This discussion was sometimes down to the level of individual patients to meet specific needs.

Following the 9am tactical meeting, a system-level meeting took place which was triggered by the level of stress the hospital was under. The hospital was noted to be at 'Operational Pressures Escalation Level' (OPEL) framework level 3 meaning that it was under "major pressure" and actions were required by all partners in the integrated care system's A&E delivery board.

Issues were generally discussed at a higher level but sometimes the conversation came down to the level of an individual patient and their specific needs. We noted at the time there were difficulties in getting patients into mental health beds and one patient had been waiting, in unsuitable circumstances, for 39 hours in the ED for a placement.

The ability to discharge patients from the hospital was a key factor in releasing beds and maintaining a flow of patients. Representatives from the independent ambulance provider of patient transport services was present at the tactical meeting. The patient transport service was contracted by the Integrated Care Board but tasked by the trust meaning that the ambulances could not be diverted to other activities. However, we were told that this service was not available to repatriate out of area patients and they were often stuck waiting for transport to be arranged by commissioners in the area in which they lived.

Doctors told us one of the causes of flow problems was getting the patients who were medically fit home from hospital. Each day around 60 patients needed to be discharged from the ED and 400 from the hospital. Flow out of the medical beds was on the risk register as it was so important to the ED and the clinical director for the ED chaired the trust's outflow meetings.

Other causes were recognised as insufficient capacity in the community and some hospital processes to discharge were "complicated." An example given by several staff was getting take-home medicines correct. The pharmacy often came back with queries about medicines which delayed discharge.

We noted that the trust's facilities and estates departments were present at the tactical meeting, and both were very responsive in dealing with issues where they could that were affecting the effective running of the ED.

Urgent and emergency services

Escalation

There were clear standard operating procedures to ensure it was recognised in the wider trust when the ED was under significant pressure and remedial action was required. The adult emergency department escalation plan defined amber, red and black states for each of the ED areas. This was following the national model for escalation metrics. These states were usually defined by the number of patients in the area, the recent inflow and how long patients were staying in the area. Other factors, such as time to assess or treat, staffing levels and the staff's perception of the risk in the area were also considered.

Each area had a matrix of actions to be taken both within the ED and trust-wide with an escalation checklist ensuring other departments acted to destress the ED where they were able to help. A key action was 'rapid flow' where wards and specialties were obliged to take patients out of the ED in excess of their own capacity. For various circumstances there were requirements to raise the OPEL and inform the relevant trust crisis management command.

Similar arrangements existed for the children's ED which took account of its smaller size and therefore capacity to absorb stress, and its less complex pathways.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The notes of various governance, team and quality meetings demonstrated that complaints were discussed with staff and means to address issues explored.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We asked for examples of recent complaints and noted that they were dealt with properly and according to the trust's policies.

Staff could give examples of how they used patient feedback to improve daily practice. The most common complaints were waiting times and the treatment received.

Is the service well-led?

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 patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge, experience, and integrity to run the service. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Staff told us leaders were visible and approachable. Staff we spoke with in the emergency department, and specifically band 5 nurses, said the leadership was both visible and approachable from the senior executives to the departmental leadership team, and their own line managers. They all said they felt well supported and able to approach anyone they needed to for advice and guidance. They felt they worked as a strong well-led team.

There were clear priorities for ensuring sustainable, compassionate, inclusive, and effective leadership, and a leadership strategy and development programme, which included succession planning.

Nursing Leadership

The size of the ED meant there were many senior staff to supervise and manage the staff and the department. This allowed for a deputy head of nursing presence in the department 5 days a week. The ED employed 11 matrons, and all had a specialised area of responsibility as well as covering the matron of the day role from 8am to 8pm 7 days a week.

The department had also increased the numbers and presence of band 7 nursing staff and we were told band 7 nurses were very present and approachable as were the senior nurse managers. Several staff told us that the increased numbers of band 7 nurses and having the management closer to the floor got things that needed doing done, taking pressure of the other staff. A staff member told us there was “less hierarchy and better teamwork.” Because they were on the floor they could also “roll their sleeves up” and provide immediate extra resource.

In another example of the devolution of management responsibility, staff told us housekeeping had improved because of the appointment of a local team leader.

We observed nursing handover meetings which, because of the size of the department, had individual groups going to different areas for a handover from the nurse in charge for that area including allocation to tasks and roles. Following start of shift there was a senior walkaround to offer support and pick up any issues raised in the local area huddles. This process was valued by the staff and the leadership.

Medical Leadership

A senior doctor told us they were proud of the team. There had been work undertaken to break down barriers between the medicine department and the ED. Even though the teams were in the same clinical group, there had been some concerns, but improvement was seen through the new system of medical in-reach. Improvements were now being seen and considered to be sustainable.

Senior staff also told us the executive team were more focused on ED than in the past but that perhaps not everyone in the trust saw ED as a problem that was theirs too.

We observed the handover meeting with medical staff at the start of day shift. This identified that staff were present and allocated them to roles and responsibilities across the department. There was a short teaching session on the risk assessment of venous thromboembolism and emphasis on the importance of this for patients staying for a long time in the department.

Urgent and emergency services

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.

There was a clear vision and a set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans was monitored and reviewed.

Culture

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

The staff we met told us they felt supported, respected, valued and were positive and proud to work in the organisation. We recognised a strong culture of support and excellent teamwork. A band 5 nurse told us how they had been supported and encouraged to take on more responsibilities and provided with the training and skills to do that safely and effectively.

In the NHS staff survey of 2023, the staff in the emergency and specialist medicine directorate reported better results in the 8 questions than the overall trust staff. This was for around 1,400 staff responding.

The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vision and values, regardless of seniority.

There was a good peer support network. A peer-to-peer support network had been established by the trust where staff could sign up to be a ‘listening ear’ for one another and support with welfare and any other emotional or practical support. We met one of the band 5 nurses who had both used the service and was now a peer supporter. They spoke of the connections they had made with other staff and found value in both being supported and giving support to others.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and was action taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations.

Urgent and emergency services

The 2022 NHS staff survey was negative about physical and mental health and wellbeing including being exhausted and burnt-out. However, there was a strong emphasis on the safety and wellbeing of staff. Staff had access to independent health and wellbeing and counselling services funded by the trust. Other staff support included exercise classes and mindfulness. Debriefs were arranged following child deaths and an additional revisit with staff one month later to allow the time to reflect.

There were cooperative, supportive, and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively.

The department was inclusive in encouraging staff at all grades and roles to become involved with development and innovation. Band 7 nurses were given supervisory time to support to improve skills and competency. Band 6 nurses were given admin time and support to carry out projects and newly qualified band 5 nurses encouraged to be involved in shared decision making to help with innovation and teambuilding. The monthly full ED team meeting was open to everyone working in the department including those in ancillary roles. There was a monthly consultant-led meeting where the team went through deaths and interesting cases to which again everyone was invited.

Several staff told us that morale had improved in the department and one band 6 staff nurse said that this “massive improvement” was due to better teamwork as a result of the work of their band 7 colleagues. A nurse who recently joined the children’s department told us that the team had been very welcoming. When we spoke to staff who had recently joined the department, they all spoke positively of the welcome they had received and how they felt valued and needed. An overseas nurse had had a very positive experience and said they would recommend the department as a place to work. They told us how the trust and colleagues had provided support to them and their family with aspects of settling into a new country outside of their work. A healthcare assistant said it was a “really good place to work” and with better staffing and reduced patient volume it “would be perfect”.

Equality and diversity were promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. However, the service was still using the acronym ‘BAME’ (used also as the word “bame” among some staff) or ‘Black, Asian and minority ethnic’ to describe people from an ethnic minority. This term was replaced with ethnic minority under Government advice in 2021 as it was found to be not fully inclusive and emphasised certain groups to the exclusion of others.

Governance

Leaders operated some effective governance processes but were not given sufficient time to do this important work thoroughly. 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.

The department sat within the emergency and specialist medicine clinical management group but was separated out under its own clinical director, deputy head of operations and deputy head of nursing. There were effective structures, processes, and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved.

Nevertheless, there was an effective audit programme running in the department. This included audit for sepsis, repeat observations, VTE assessment, and meningitis management. There was an extensive list of audits required but also the flexibility in the programme to introduce audit routines for emerging risks or falling performance. This had included delivery of anaesthetic for people with broken hips and the provision of MRI scans for people with a suspected serious spinal condition. There were processes to manage current and future performance reviewed and improved through a programme of clinical and internal audit. For example, this was demonstrated by the lack of an effective audit

programme, including for sepsis management. There were processes to manage current and future performance which should be reviewed and improved through a programme of clinical and internal audit. Audit was managed through the trust's clinical audit department which liaised with the clinical audit committee and the department clinical audit lead nurse and lead doctor. We requested and were provided with information about the ED's audit activity. This showed that while there was audit activity, much was at the level of projects for foundation year doctors. Furthermore, the department did not currently participate in the Royal College of Emergency Medicine's annual audit programme.

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.

The organisation had assurance systems and performance issues were escalated through clear structures and processes.

Leaders monitored quality, operational and financial processes and had systems to identify where immediate action should be taken to respond to new or emerging pressures. Reports demonstrated action was taken around operational performance when required and improvements monitored.

There were arrangements for identifying, recording, and managing risks, issues, and mitigating actions. There was alignment between risks recorded in the departmental risk register and what staff told us was on their worry list. The risk register was comprehensive and detailed and senior staff demonstrated a strong knowledge of its contents to the extent that they would quote the numerical score of individual risks. Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

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.

Information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings at all levels.

Staff had sufficient access to information and challenged it when necessary. There were clear service operational performance measures, which were reported and monitored with effective arrangements. This was to ensure the information used to monitor, manage, and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records, and data management systems were in line with data security standards. Lessons were learned when there were data security breaches.

There was a sophisticated system for tracking patient acuity, occupancy and waiting in the ED which was integrated with other trust systems. This was visible throughout the department and used constantly for patient and departmental management. Computer aided dispatch information was available from the ambulance service and used to predict immediate demands on the department.

Engagement

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

People's views and experiences were gathered on and acted on to shape and improve the services and culture. This included people in a range of equality groups, people who used services, and those close to them. Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance.

CQC urgent and emergency care survey results 2022

Although we recognise this data, captured towards the end of 2022, and published in 2023, is not as current as would be hoped, it contains some valuable contribution from patients.

The trust scored 'about the same' as other NHS trusts for all 9 sections in the CQC type 1 urgent and emergency care survey 2022. The trust scored 'somewhat worse' than expected for one question: feeling that staff explained why they needed a test in a way they could understand.

The trust scored 'somewhat better' than other trusts for one question, and 'better' than other trusts for one question:

- Information about self-care – being given enough information to care for their condition at home (better)
- Communication needs – staff helping with communication needs (somewhat better)

The trust scored 'about the same' for 34 questions.

There were 105 responses to the 2022 survey which were valid for analysis in 2023. Long waiting times were consistently brought up by respondents, who commented on having to wait to be examined and/or transferred to a hospital ward. The long waiting times impacted both those who attended A&E personally, and respondents who used the ambulance service. One individual recounted waiting for more than an hour in an open ambulance vehicle on a cold evening, causing them to be admitted to A&E late at night, "shivering and shaking" due to the low temperature.

Long waiting times were also mentioned in positive survey responses. Indeed, even those who did not mind waiting and made appropriate adjustments (for example, bringing plenty of water, or things to keep themselves busy) reported spending a long time in A&E before being seen by members of staff. One respondent commented how: "The staff were, without exception, kind, encouraging and calm, […] This made a great difference when trying to remain optimistic while waiting 11 hours in A&E."

Urgent and emergency services

Interactions with staff were frequently commented on in the survey responses, and the experiences service users reported were mixed. Firstly, several respondents described members of staff as kind, supportive, competent, and caring. Others instead reported bad experiences characterised by receptionists, nurses, and doctors acting dismissively and uncaringly, including not listening to service users.

A significant issue involving staff interaction was poor communication. When comments described bad experiences with staff, it was often due to a breakdown in communication, and/or incorrect information being provided to respondents. A respondent told us: “My first doctor told me I had a condition. Never explained it. I was given medication by a nurse with no explanation why I was taking it. Then it turned out I didn't have that condition. It was something completely different.”

Many individuals commented on a lack of physical support by staff. Respondents were sometimes left alone unattended for long periods of time. This was particularly distressing for elderly people and those with pre-existing conditions that required additional assistance from members of staff but did not receive any. This perceived lack of physical support was intensified by other issues such as low levels of staff and the long waiting times that some service users faced. Overall, the lack of assistance led to a worse quality of care for many survey respondents.

A respondent told us: “I was left for long periods without any assistance from nurses or doctors. My wife was with me, and she had to go and [find] someone for help. This was not easy for people in their eighties.” Another said: “Even though I had my light on, nobody came to my compartment, and I needed the toilet. This was embarrassing. I was waiting over one hour and unfortunately, I had to pass water in the bed.”

Respondents commented on facilities being understaffed and/or medical professionals being overworked. A&E services were at full capacity due to a lack of staff. According to the comments, medical professionals, even when described as competent and providing support to patients, could not manage with the number of people they were looking after which resulted in inadequate care being provided.

A respondent said: “there are very few doctors and nurses and so the waiting time is a nightmare. Recently in the last 6 months I have been to the A&E a good few times and the waiting time was nearly thirteen hours. I was definitely not happy at all. So, I wanted to request you to make arrangements for more doctors and nurses to help manage patients.”

Discussions about staffing levels and capacity occasionally extended to the NHS as a whole, as some respondents criticised the service as being overstretched. They identified the NHS’s general lack of resources as the potential cause of the understaffing issue.

Often, the physical environment of the A&E service was under scrutiny by survey respondents. Some of them described a lack of privacy, poor hygiene, inadequate temperatures, and/or unsafe conditions due to noisy and dangerous people attending the unit, causing stress and anxiety to some individuals. Sometimes these concerns were further exacerbated by the long waiting times.

Some respondents commented on the lack of options when it came to food and drinks, such as the machines being broken, whilst having to wait. This caused further distress to those with pre-existing conditions such as diabetes, who found it harder to accommodate their dietary requirements.

Most survey respondents indicated that they were satisfied with the quality of care they received generally. Even when their comments focused on problems they experienced, such as long waiting times, members of staff acting rudely, and/

or a stressful A&E environment, respondents were still grateful for their treatment and overall care. This is common in many survey responses, as individuals provide a general positive statement on their care before focusing on details of their negative experiences. This may indicate respondents not wanting to come across as overly negative, and a similar trend was observed in this survey.

A respondent said: “Once I had my treatment and looked after extremely well, I felt a lot better. It was the waiting time that made it so hard to cope with.”

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.

Leaders and staff aspired to continuous learning, improvement, and innovation. This included participation in appropriate research projects and recognised accreditation schemes. There were standardised improvement tools and methods, and staff had the skills to use them. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation. There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.

Band 6 nurses were given time to participate in project work and band 5 nurses were encouraged to be involved in shared decision making to help with innovation and teambuilding. A band 6 nurse told us “Our ideas are taken seriously”.

Several staff of varying grades told us that they were encouraged to come up with ideas and that there were forums for this. Example was a nurse-initiated pack for people with learning disabilities consisting of ear defenders, a stress ball, a fidget spinner, crayons, and an eye mask.

Areas for improvement

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

Action the trust MUST take to improve:

Emergency department

- Care and treatment must be provided for patients in a safe way. The trust must ensure staff are assessing the risks to the health and safety of patients of receiving the care or treatment. Staff must be doing all that is reasonably practicable to mitigate any such risks. To that end, the trust must ensure all patients receive timely assessment and

treatment for conditions, such as sepsis. Furthermore, the trust must ensure it continues to use all resources available to reduce the pressure on the department caused by increasing demand and ineffective and inefficient movement of patients onwards in their pathway. This includes the significant improvement to the agreed professional standards which remain non-compliant in most specialties. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

Action the trust SHOULD take to improve:

Emergency department

- The trust should ensure staff in the emergency department are up to date with the latest mandatory training modules and staff, particularly medical staff, are given time to meet compliance.
- The trust should ensure staff in the emergency department adhere to infection prevention and control policy specifically in relation to dress code and any temporary measures introduced to prevent the spread of infection.
- The trust should ensure staff have the right tools to be able to open locked doors when patient safety is a concern.
- The trust should continue to build on the work on staff recruitment and retention and look for support from other departments, such as rotational work with children's nurses, as an option to build stronger and more flexible teams in the department.
- Due to patients having to stay far longer than planned or anticipated at times, the trust should consider how to meet the dietary needs of patients to ensure they are provided with food and drink in line with their cultural or other requirements.
- The trust should ensure staff are given sufficient quality time to complete a programme of good and effective governance. This should follow a recognised system of governance routines, including analysis of all forms of evidence and engagement.
- The trust should consider how it describes staff from ethnic minorities to bring the language into line with current practice and keep this under review.

Maternity

Requires Improvement  

Summary of this service

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

- Staffing levels did not always match the planned numbers putting the safety of women, birthing people, and babies at risk.
- The trust had a higher number of extended perinatal deaths when compared to other similar hospitals.
- Staff didn't always report all incidents so there were potentially missed opportunities to learn from them.
- Although staff kept equipment and the premises visibly clean in most areas, some essential building works had impacted upon this.
- The Women's governance board did not always monitor data specific to each hospital location.
- Although there were improvements since the last inspection, there was further development and actions to and embed improvements across the service.

However:

- Most staff had training in key skills.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so.
- Staff felt respected, supported and valued.
- The service engaged well with women and the community to plan and manage services and all staff were committed to improving.
- Leaders had the skills and abilities to run the service and knew where improvements were needed.
- Leaders were visible.
- Since the last inspection, the service had implemented an enhanced telephone triage service and used a nationally recognised tool to identify women and birthing people who were at risk of deterioration.

Is the service safe?

Requires Improvement 

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

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it.

Most staff received and kept up-to-date with their mandatory training. The service supplied service level compliance data for their obstetric training for Leicester Royal Infirmary. Since the last inspection, the service had carried out work to enable training compliance data to be split by hospital site.

The mandatory training was comprehensive and met the needs of women and staff. In January 2024 the mandatory training figures showed Obstetrician and Gynaecology medical staff achieved a compliance rate of 97.53%, while Nursing and Midwifery staff reached 95.80% compliance, aligning with the trust target of 95%.

Fetal Monitoring training compliance ranged between 80-100%, with an action plan submitted to achieve 90% compliance.

Most staff were up to date with their mandatory multi-disciplinary PROMPT (Practical Obstetric Multi-Professional Training) skills and drills training (which was part of the saving babies lives training day). Compliance ranged between 96-100% for medical staff across the whole service and between 73-100% for midwives and maternity support workers. An action plan was devised and shared to ensure training achieves 90% compliance.

We saw key training for equality and diversity was in place with compliance at 98% overall. We saw resuscitation basic life support training was 100%. Training for infection and prevention control was just below service target at 91% and fire prevention was 91%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders reminded staff to complete training through local team meetings. Maternity services were supported by an education team to improve training and development. The service's training figures reported were discussed at board meetings, and whilst the maternity incentive scheme (MIS) national target for mandatory training was set at 90%, the service had set an aim to achieve at least 90% compliance with mandatory training, working towards a service compliance rate of 95%.

We saw how the service was monitoring training compliance as part of their improvement work since the last inspection. A Red Amber Green (RAG) rating system was being used where more work was needed to increase compliance in some areas. For example, in January 2024, the service reported that not all the maternity service staff had completed their mandatory sepsis training, so this was rated as red because it was below 90%. However, training data showed that in January 2024, 90% of maternity multidisciplinary staff had completed the Growth Assessment Protocol (GAP and Grow) which was in line with the service's target.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. We spoke to staff across maternity services who were able to give examples of caring for women with mental health needs.

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.

Maternity

All staff received training specific for their role on how to recognise and report abuse. All staff training compliance was above 96% for adults and children safeguarding levels 1 and 2. However, the overall compliance training for safeguarding adults level 3 was 87%, which was below the trusts own target of 95%, Compliance ranged from 100% for obstetric management to 57% for senior nurses and midwives. There was a plan in place to further improve compliance where required.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. We spoke to consultants during the inspection, and they were knowledgeable about how to report a safeguarding concern and were able to give examples of abuse. Leaders and staff understood the demographic area and diversity of women with high risks and had a clear understanding of high-risk women admitted to maternity services. For example, staff risk assessed women who may have been at a greater risk including those from ethnic minority groups and made appropriate arrangements. We saw a risk assessment and escalation policy in place and staff and leaders understood the risks within the population.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to access an 'app' to see policies across maternity services. Maternity services were supported by the team and lead safeguarding midwife for all locations. This team was further enhanced following the last inspection to strengthen safeguarding supervision for staff and was working towards improving safeguarding. The team understood the risks, exploitation, and domestic abuse and actions to safeguard women and babies. Staff were able to demonstrate and give examples of safeguarding concerns for adults and children.

The service had a Named Midwife for Safeguarding (1.0 WTE) who managed a team of safeguarding specialist midwives (2.8WTE), along with other Specialist Midwives who cared for vulnerable women. This included substance misuse and mental health specialist midwives (3.0WTE). At the time of the inspection, there was a vacancy within the specialist team for a teenage pregnancy and complex needs specialist midwife post. This post was filled following the inspection.

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

Staff followed safe procedures for children visiting the ward. The staff used safe processes for entering all areas and used a swipe card. All areas were monitored and overseen by the ward clerk on wards 5 and 6. We observed staff communicate appropriately with other professionals, women, birthing people, and visitors on antenatal and postnatal wards.

Staff followed the baby abduction policy and undertook baby abduction drills. The service had a baby abduction policy, and this was established in September 2023 and staff undertook baby abduction drills training in December 2023 across all sites.

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 in most areas, but some essential building works had impacted upon this in a couple of areas.

Maternity

Ward areas were mostly clean and had suitable furnishings which were clean and well-maintained. We observed cleaning on the first day of inspection across all areas. On ward 5, we saw some accumulated dust in corridors and bathrooms and some toilets were not always clean. A disposable sick bowl was left in the toilet and not disposed of appropriately. However, following immediate feedback to leaders, cleanliness in the areas visited on the second day had improved.

During the visit, two external agencies were present alongside ongoing internal estates works. Upgrades to the Fire System and preparations for implementing the new Baby Tagging System were underway. Environmental improvement works were also ongoing. These works had begun the week of the unannounced inspection. Despite additional cleaning regimes, the impact of concurrent works was evident. Enhanced communication across operational and estate colleagues had been implemented and leaders took immediate action to address issues observed during the inspection. We noted the team responded in real-time to the evolving situation.

On the second day, we found that the birthing persons areas, in wards 5 and 6, the maternity assessment unit (MAU), and delivery suite were all visibly clean. During the visit, two external agencies were present alongside ongoing internal estates works. Upgrades to the Fire System and preparations for implementing the new Baby Tagging System were underway. Environmental improvement works were also ongoing. Despite additional cleaning regimes, the impact of concurrent works was evident. Enhanced communication across operational and estate colleagues had been implemented. These works had begun the week of the unannounced inspection, and leaders took immediate action to address issues observed during the inspection. We noted the team responded in real-time to the evolving situation.

The service had replaced furnishings following our last inspection in some areas and these were clean and suitable. We saw a parent room and a room newly established on ward 5 for families and relatives to use and this was visibly clean. We saw that disposable curtains were visibly clean and dated.

The service generally performed well for cleanliness. Cleaning records were mostly up-to-date and demonstrated that areas were cleaned regularly. We observed some gaps in cleaning records for ward 5 in November, December 2023, and January 2024. Staff told us sickness and absences had impacted on the cleaning. We informed leaders who took immediate action to address this during our inspection.

There was improvement in the oversight of infection prevention and control through the senior leaders' meetings. These were well attended by midwifery and medical staff. Leaders monitored infection control audits and they shared information about compliance with local teams. Infection prevention and control and cleanliness performance data was displayed in clinical areas.

We saw that matron's were involved in environmental audits. We identified areas of good practice with medical staff having links to infection, prevention and control. We also found improvements since the last inspection regarding the tidiness and organisation of the wards and departments. Some estates' work had also been completed since the last inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff using hand sanitizers on the delivery suite, and on wards and adhering to the 'bare below-the-elbow' policy. The Trust' hand hygiene audits for December 2023 showed an overall compliance rate of 95%. Data showed average hand hygiene compliance had increased each month since July 2023.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. Equipment was visibly clean, apart from in some areas where building works were being carried out, with some dust accumulated on some equipment labelled as 'clean' in ward 5. This was immediately addressed following feedback to senior leaders and had improved on the second day of the inspection.

Environment and equipment

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

Women could reach call bells and staff responded quickly when called. Call bells were accessible to women and birthing people if they needed support and we saw that staff were responsive to call bells on the days of the inspection. Women we spoke with confirmed that staff responded for support with their care.

The design of the environment generally followed national guidance. Following our last inspection, transformation of the maternity service was underway. The maternity service was operating out of a very old and historical hospital building, but there were plans in place to make improvements where possible. For example, there had been improvements made to the facilities in ward 5.

During the inspection, work was ongoing to enhance the fire safety systems.

Access to the maternity wards and theatres was controlled by a ward clerk. There was secure access to the MAU, maternity wards, and delivery suite through staff card access along with a monitored entry and exit system. We saw staff speaking to people entering wards 5 and 6 to maintain safety protocols.

The triage and Maternity Assessment Unit (MAU) was located on the first floor. There was a reception/waiting area, 2 triage assessment rooms and a 4-bed bay along with a staff office and further waiting area. Since the last inspection changes had been made to the environment for the telephone triage. There was a separate office for telephone triage located on the ground floor remote from the triage/MAU on the first floor. Staff told us this was working well.

The delivery suite was located on the fourth floor, and we saw some improvements in the furnishings (with more on order), and a plan was in place to continue to improve the environment.

The service had suitable facilities to meet the needs of women, birthing people and their families. Following the last inspection, the service had improved facilities for parents and families. On Ward 5 there were improvements so that parents and families could now access beverages. Staff informed us that facilities for parents and families were more personable than they used to be. We saw visitors using these facilities during the inspection.

The service had enough suitable equipment to help them to safely care for women and babies. The Director of Midwifery told us that since the last inspection, there had been improvements to the oversight of equipment checking. There had been some investment in purchasing new equipment and some more replacement equipment was still to arrive. This was part of the maternity improvement plan.

Staff carried out daily safety checks of specialist equipment before use.

Safety testing of electrical equipment was due in February 2024 which was part of a scheduled programme. Leaders told us there was a designated person who had the oversight for repair and routine checks.

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

Assessing and responding to patient risk

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

Since the last inspection, the service had implemented an enhanced telephone triage service and used a nationally recognised tool to identify women and birthing people who were at risk of deterioration. Dedicated midwifery staff had a base separate from other areas in order to undertake telephone triage. We saw, and staff told us, that the telephone triage process had made significant positive improvements to the flow and safety of women and birthing people as well as improving staff wellbeing. Leaders provided evidence of continuous monitoring of timescales to answer the triage telephone calls giving assurance that telephone calls were being answered and managed appropriately.

The triage service used an electronic notes system that recorded all previous calls, relevant safeguarding information and recorded the risks of women being triaged. Calls were flagged and staff were able see if there were any safeguarding concerns or alerts. Staff spoke positively about triage and told us it was well staffed.

Staff used a risk assessment tool based on the 'Birmingham Symptom Specific Obstetric Triage Score' (BSOTS) for maternity triage. The service had made significant improvements to the triage process and dedicated staff were allocated to triage and protected from being pulled to work in other areas. We saw staff using the service's BSOTS proforma as a prompt to help them with the assessment process.

Leaders had oversight of performance in relation to the triage and MAU through a dashboard. Audits. Audits were presented through Maternity Governance as part of monitoring and oversight.

Leaders had recognised that waiting times for doctors were longer out of hours and there was ongoing work to address the level of medical cover. The service were working towards improving a workforce dedicated to women attending the MAU which would improve the time women had to wait to be seen by a doctor.

Women and pregnant people had their arrival time recorded when they entered the MAU. The triage time was recorded at the time they were seen by the triage assessment midwife. This was documented in the triage assessment and the data was then used for audit purposes. Monthly audits showed the services was consistently meeting its triage time of 15 minutes within arrival.

In order to help manage risk and flow of women during busy periods, the telephone triage midwives were able to see the capacity at each of the MAU's across the trust so they could ensure appropriate bookings into the unit with admitting capacity.

Staff used the nationally recognised Modified Early Obstetric Warning Score (MEOWS) to identify deterioration in the health of women and birthing people. Staff used an electronic system to document and score MEOWS. The service had completed a sample audit of 150 sets of records between July 2023 and December 2023, and showed leaders staff had correctly completed the records.

Leaders said that since the last inspection, a service wide electronic process Situation, Background, Assessment and Risk (SBAR) Alert system had been implemented. This process alerted staff if a 'reg flag' parameter was met, e.g. maternal heart rate over 140bpm, but if the reason for this outlier was known and sepsis was not suspected clinically,

the option to ‘stand down’ the sepsis alert was possible at the point of inputting the observations (by a registered midwife). The responsible midwife in charge was notified of this raised risk and then provided additional support to staff who were alerted to review the women or birthing person. The Sepsis Screening Tool had been updated since the last inspection which included reference to the Maternity Early Obstetric Warning Score (MEOWS).

Staff completed risk assessments for each woman on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff understood how to complete individual risk assessments on all women and birthing people including risk assessing for sepsis and identifying emerging risks using the risk assessment tools. Staff knew about and dealt with any specific risk issues.

The service had produced an updated, approved caesarean section guideline since the last inspection, which now included detailed guidance on the removal of surgical drains.

Since the last inspection, the service had established a policy for babies who were not medically fit for discharge and who were to be adopted or fostered. The service could evidence an in-date and approved Standard Operating Procedure titled ‘Unaccompanied Babies in the Maternity Unit’. This was designed to provide comprehensive care and support for babies who were without a legal guardian. This protocol was designed to address situations where babies were left unaccompanied due to various circumstances, such as a mother requiring medical attention in a separate area, or concerns for the baby's safety pending court decisions or local authority arrangements.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman’s mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff completed risk assessments for women and birthing people on arrival, and we saw improvements during inspection that this was done consistently and reliably using a recognised tool. We observed detailed ligature risk assessments accessible to staff in wards 5 and 6 and leaders said that Health and Safety Services had assessed and updated relevant risk assessments in June 2023. This was shared by managers to the local teams, and they raised staff awareness through their local meetings. Staff were able to access the ligature risk assessments.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. Shift changes and handovers included all necessary key information to keep women and babies safe.

The service had taken action to keep women and birthing people safe including the use of an induction of labour (IOL) pathway. Staff told us that in September 2023, leaders re-established the IOL working group to agree immediate risk mitigations as well as medium-term priorities to ensure the pathway was fit for the future. The service had dedicated IOL midwives to facilitate flow and enhanced care for women and birthing people. Two new staff had been recruited for the LRI hospital and were due to start at the end January 2024. An SOP called ‘Escalation Process for Women Experiencing Delays in Induction of Labour,’ had been implemented in November 2023 which included a ‘pop up’ Day Assessment Unit. This unit was set up within the antenatal clinic and was activated when there were any delayed inductions that required an assessment. It was a six-day service operating in daytime hours. The service was provided for women and birthing people who had just started their induction, those whose induction was ongoing and required assessment. Women and birthing people had a point of contact for any queries or concerns from the point of booking their induction. One benefit of the pop up service was that women and birthing people were likely to see or have access to the same midwife throughout their induction and have a clear point of contact which aimed to improve both safety as well as a women’s experience in case of delayed inductions.

An IOL 'app' had also been rapidly developed which was to provide regular performance data. This was due to be launched on 5 February 2024. This had been developed with regional colleagues and an evaluation of the impact was planned. The 'app' worked by stratifying the woman and birthing person's clinical risk, considering the pregnancy history and current clinical picture, including but not limited to the following factors: 'presence of meconium', pre-eclampsia, post maturity. Women and birthing person's care was then in accordance with their individual care pathway, regardless of whether they had commenced clinical intervention, the 'app' automatically updated and escalated the case to the clinical team, using red, amber and green indicators. Training had already commenced amongst the multidisciplinary team (MDT) that were to be responsible for completing these assessments.

The service had developed a number of specialised clinics for example: Iris Clinic for Female Genital Mutilation (FGM) and Haemolytic Clinic for conditions like sickle cell and thalassaemia. Additionally, there were other specialist clinics for the whole population served including: Diabetic Clinic, Perinatal Mental Health Clinic and Maternal Medicine Clinic. However, leaders told us there were more improvements needed to provide more diabetic nursing support for pregnant women.

It is nationally recognised that inequalities in health can impact maternity outcomes, as can other contributory factors including demographic, socio-economic information, pregnancy complications, screening, engagement with service and the need to use interpretation services. Staff were provided with equality and diversity training to help support women and families from a diverse background. When we spoke with staff they were able to demonstrate an awareness of the population they served across the area of Leicester, Leicestershire and Rutland. Leaders were assessing performance and outcome data by ethnicity and demonstrated an understanding of the importance of this.

Nurse staffing

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

The service did not always have enough nursing and midwifery staff to keep women and babies safe. However, there were related escalation / redeployment / tactical responses to manage risk. One to one care in labour was always maintained.

During the inspection, we were told staffing was low, due to short notice sickness absence. We saw discussions between coordinators to deploy staff to maintain safe staffing levels across the maternity service, with staff redeployed to support areas most in need.

The service leaders had commenced a detailed and ongoing recruitment programme, working with the national challenges of midwife vacancies. The service reported in December 2023 that it had a current vacancy of 28 whole time equivalent midwives. The acuity tool had identified that the staffing levels for the three months prior to our inspection showed the service was on average 3.5 midwives short of the desired. We noticed this was improving as new staff were being employed. Leaders prioritised the filling vacant shifts and staff absences.

The service reported significant midwifery safe staffing shortages in each month from April 2023 to November 2023.

- In August 2023, the actual midwifery staffing level was reported as 11,529 hours compared to the planned 14,304 hours.

Maternity

- In September 2023, the service's actual midwifery staffing was reported as 10,878 hours compared to the planned 14,203 hours.

- For October 2023, the service had planned 13,633 hours for midwifery safe staffing, however the actual level was 10,520 hours.

However, the overall occurrence of unfilled vacant shifts had seen a consistent decline and was- improving due to new recruits commencing specifically during November & December 2023. There was also a notable upward trend for unexpected staff absence with a decline in the following months.

The fill rate on the Delivery Suite varied from 74% to 95% across December 2023- February 2024.

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

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

The service had recruited 57 new midwives who were in the process of joining from January 2024. Service leaders had offered flexible working arrangements to attract more staff to work in the service.

The service had reducing vacancy rates and was at 9.7% in December 2023, and then 8.5% in January 2024. This had reduced following the last inspection and the service was waiting for a further 15 midwives to start in Spring 2024. The sickness rate was improving at 8% and the turnover rate 3.79%.

The service utilised bank and agency staff to maintain safe staffing levels. Whilst the utilisation of agency staff was minimal there was a rapid onboarding and induction package in place.

The service was fully staffed with midwifery support workers.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders told us that the staffing establishment was funded in line with a national acuity tool. Staff used the tool to plan staffing levels and monitor the impact of when staff had been moved. The service used a safe staffing and escalation policy which was incorporated into the twice daily senior leadership "tactical" meetings to safely manage the service.

Managers could adjust staffing levels daily according to the needs of women. A joint tactical meeting took place twice a day as a minimum to support and collaborate working across the trust's sites to maintain safety. This included reviewing staffing levels that were calculated according to the number women and birthing people in the units along with the flow of admissions and discharges. Leaders said they could adjust staffing levels daily according to the needs of women and birthing people.

Maternity

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 and babies safe. The service told us they had recruited an additional 9 specialty doctors to Maternity Assessment Unit (MAU) with the aim of increasing out of hours cover in obstetrics and gynaecology, to improve waiting times. In the interim, they had mitigated this risk by putting junior doctor cover shifts out to locum cover. This measure would remain in place until the specialty doctors had started later in 2024.

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

The service had low vacancy, turnover and sickness rates for medical staff. The turnover of medical staff was low, and the maternity service had no vacancies for medical staff. The service always had a consultant on call during evenings and weekends.

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

Records

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

Women's notes were comprehensive, and all staff could access them easily. Women's notes were comprehensive, and all staff could access them easily. The service used a combination of electronic and paper notes. Risk assessments such as VTE (venous thromboembolism), MEOWS and handover information was accessible.

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

Records were stored securely and kept locked. Computers were locked with a password. We saw this had improved in all areas since the last inspection. White boards that contained people's details were displayed in hidden areas for staff only.

Medicines

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

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

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

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

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

Incidents

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

Staff knew what incidents to report and how to report them in line with service policies and procedures, but some staff felt they did not always have time to report incidents. Leaders and staff knew the importance of raising an incident, but some staff told us this would vary from day to day and depend on capacity within maternity services. This was on the risk register and reporting had improved since the last inspection.

Staff usually raised concerns and reported incidents and near misses in line with trust/provider policy. We saw that an incident was raised about staffing levels on the day of inspection on ward 5. However, some staff said there was not always have the time to do this and it was not always consistently managed across maternity services. Leaders were working on making improvements and recognized there was still ongoing work to be done.

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

The quality improvement team led an open-door policy following the previous inspection where staff could learn and ask questions to improve.

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

There was some evidence that changes had been made because of feedback and bulletins and emails were used to share learning with staff. For example, we saw one incident which related to the manual removal of the placenta and difficulties delivering the placenta. The learning points were cascaded and shared amongst staff through bulletins and emails across the service.

Managers investigated incidents thoroughly. The trust had improved their work to involve women and their families in investigations and recognised they had further work to do.

Managers debriefed and supported staff after any serious incident.

Maternity

All NHS maternity services work towards "Saving Babies' Lives" which is a nationally designed ambition, to reduce the number of stillbirths and early neonatal deaths in England.

The trusts stillbirth rate fell to 3.86 per 1000 births in 2022 (3.9 nationally) compared to 4.05 per 1000 births in 2017. The stillbirth rate continued to fall and was comparable to their peer group rate (within 5% of the peer group average), however the neonatal mortality rate continued to be more than 5% higher than the mean rate for their peer group (both including and excluding congenital anomaly). The demographics in the recent MBRACE report suggest that the trust had a slightly fewer women >35 years giving birth compared to the national average, and a similar deprivation profile to the national average. The ethnicity of the women giving birth was significantly different to the national average, with a significantly higher proportion of babies of non-white origin in the population (42.5% vs 26.2%). 3.1% of babies have been reported as 'unknown' ethnicity, which is similar to the national average, but a significant improvement compared to previous years' data.

The trust did not have any intrapartum stillbirths reported to MBRRACE-UK in 2022 but a higher rate of neonatal deaths due to fetal conditions compared to the national average (8.8% vs 3.9%). These are conditions which have a very high mortality rate and for which the trust take referrals from a wide geographical area.

A new perinatal mortality review lead midwife commenced January 2024. A further peer review of cases was scheduled with another NHS trust, as well as endeavours to establish a learning consortium with large perinatal centres with associated cardiac and surgical services. The trust were working with NHS England Midlands Public Health colleagues as part of the joint work to further understand the wider determinants of health. Plans were in place to align this to the perinatal insights' dashboard and the work as part of addressing equity. There had been an increase in referrals from neighbouring smaller hospitals and an increasing complexity in women booking at the trust. Leaders told us they were committed to understanding mortality rates in fuller detail and actions were being taken. For example, they were reviewing all population groups, identifying any health inequalities across the six elements; providing access to a specialist Fetal Medicine Centre and ensuring pathways were in place to ensure timely referral and ensuring a multiagency approach linking with public health, perinatal mental health, local authority.

Leaders told us they reported all cases which were eligible to the Maternity and Newborn Safety Investigations (MNSI) programme for review.

Women and birthing people from minority ethnic groups experienced additional risks compared to white women that, without the right interventions, could lead to poor outcomes. For example, black women and birthing people are four times more likely to die in pregnancy and childbirth than white women and birthing people, for Asian women, it is two times more. Leaders told us that they had a higher than national average non-white ethnic women and birthing people population, therefore outcome differences between ethnicities, deprivation, and maternal age was a factor. Ethnicity, deprivation, and vulnerabilities information was being collated by the service to help drive improvements in patient safety.

A lead midwife for inclusivity joined the service in January 2024, taking the lead on developing the best approach for tackling health inequalities in care. Working closely with the substantive Consultant Midwife, the role was there to support the implementation of key national and local report recommendations.

Is the service well-led?

Requires Improvement 

Maternity

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

Leadership

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

At the time of our last inspection there had been some very recent changes to the leadership team. Since January 2023 there was a new Director of Midwifery (DoM), two Heads of Midwifery (HoM) had been in post since April 2023 and one Deputy Head of Midwifery in post since September 2023. A further Deputy Head of Midwifery was recruited and commenced March 2024.

To support operationally, leaders had strengthened senior roles including operational leadership roles and the quality and improvement function. The service had increased the number of operational managers. Leaders knew it was important to have the right skills and experienced people in place for better quality and safety of the care and treatment being provided. The newly appointed structure was equipped with role to support service improvement. We spoke to 10 service leaders from the head of midwifery, matrons, and project consultants and they all reported improvements and demonstrated that they were working towards implementing their improvement actions.

Since the last inspection, leaders across maternity services had improved the governance in the service. Leaders had assurance that they were progressing with their improvement programme and had good reporting and escalation structures in place.

Leaders understood their roles, responsibilities, and accountabilities and were open and honest with their progress and the improvements that were still required.

Leaders reported improvements to triage, induction to labour (IOL) and infection, prevention, and control processes across maternity. During the inspection, we identified some continued delays to IOL processes which leaders had plans in place to address.

Leaders understood the demographic area of the local community and the risks of the diverse local population. Leaders said there was still work to be done working towards making sustained improvements, but they had a clear understanding of the risks and challenges faced by the service.

Staff spoke positively about the Director of Midwifery and Chief Nurse during the inspection with their increased visibility across maternity and neonatal services. However, some staff felt some historical issues had not always been dealt with and were still ongoing. We spoke to leaders about the work that was ongoing to transform the service's work along with People Partners who were aligned to the service. We were assured there was ongoing work and leaders openly discussed how they were planning to improve support for all staff and women. Empowering Voices was a further vehicle for capturing cultural and operational issues which needed addressing. During our visit, the Guardian Service visited staff areas to promote their role and increase accessibility. Leaders recognized that culturchange took time, but leaders were taking appropriate steps to address this.

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 service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust had developed the vision and strategy in consultation with staff. The strategy identified key priorities which included: listening to women and birthing people to provide personalised care, retaining, and supporting staff, culture and leadership, and improving compliance with national maternity safety initiatives such as the Clinical Negligence Scheme for Trusts (CNST) and the Saving Babies Lives care bundle. Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services.

Culture

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

Most staff told us they felt the culture within the service was generally positive and had improved following the previous inspection. Staff told us they acknowledged that cultural change remained an ongoing issue for the service whilst working through an improvement process. Staff said that there had been episodes of bullying reported to the senior leadership team and felt that communication could be improved around allegations, but generally felt they could raise concerns with senior leaders, and they would be acted upon. Staff said that they had felt supported by the Director of Midwifery when raising cultural issues and staff felt they were listened to. Leaders continued to use the empowering voices processes due to long-standing cultural concerns.

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

The team have People Partners aligned to the service not human resources. The service has a 'Guardian Service' rather than the old FTSUR.

Empowering Voices was a further vehicle for capturing cultural and operational issues which need addressing.

It was recognised that behavioural change will take time however the team are evidencing and taking the appropriate steps to address. Leaders had changed how they listened to staff and have created an independent freedom to speak up team. The freedom to speak up staff told us the service had ongoing plans to change the culture and develop a better working environment for staff. We saw a diverse workforce across all maternity services and positive interactions between staff, women and birthing people, and visitors. They supported the diversity of languages spoken and understanding of the various in Leicestershire.

Maternity

Governance

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

Leaders were improving the effectiveness of systems and processes, including updating the service's guidance, policies and processes since the previous inspection in March 2023. However, some were still a work in progress but to manage risk, leaders had prioritised actions to reduce delays in discharges, and increasing staffing levels to prevent perinatal deaths. Leaders and staff understood risks of the service.

Since the last inspection, leaders told us there was more representation at the trust board than they had ever had. Leaders told us this had really help drive change. Leaders said there was a more inclusive teamworking culture, however, more work was required to embed accountability across all areas and grades of staff. Leaders reported feeling more supported to drive improvements.

Leaders actively monitored data and performance and transferred learning into actions.

Women's governance board meetings were held monthly. Whilst not site specific, the governance board 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 always clear from meeting minutes who the chair was, and although there was representation from a consultant obstetrician and neonatologist, there was no anaesthetic representation.

At the time of the inspection the trust told us they would be submitting a 10/10 full compliance posit for NHS Maternity Incentive Scheme (MIS). This was subsequently submitted and was externally verified and approved by NHS Resolution (NHSR).

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

The service leaders reported to the trust board through the "mortality and learning from deaths quarterly report." In December 2023, the report included information regarding learning from deaths. The report highlighted "the quarterly number of stillbirths in 2023 was similar to the pre-COVID pandemic year and there were fewer neonatal deaths in quarter 2 of 2023/2024 (financial year) than previous two quarters."

We reviewed the service's perinatal mortality review tool (PMRT) summary report for the period March 2023 to February 2024 and found that 83 cases were open for review during this period.

Work was in place which focused on improving the turnaround of the cases which is reflected in the recruitment of a new PMRT lead midwife.

Service leaders were focused improving the governance regarding PMRT and recognised there was more work to be done. A PMRT Midwife Specialist commenced in post in January 2024. All families were given the opportunity to offer input into the PMRT review and ask questions. The new PMRT Specialist Midwife had a focus on increasing the family involvement in reviews. Leaders told us this new role was already having an impact.

Maternity

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

Leaders disseminated learning by bulletins and threaded learning for mandatory training. We saw governance boards, and infographics available for staff and patients. Due to the ongoing staffing issues, clinical midwives were not always able to attend learning forums.

Management of risk, issues and performance

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

We noted many improvements since our last inspection. Leaders were aware of the risks within the service and had plans in place to mitigate risk and improve performance. Risk registers we reviewed generally reflected the risks within the service and the risks we found on inspection had been recognised by senior leaders. Leaders said a detailed risk assessment tool was completed on the patient's arrival and admission and reviewed this regularly, including after any incident.

Staff didn't always report incidents because of low staffing levels, but leaders knew about this risk and were working to address this and had it as an area of focus.

Information Management

The service collected reliable data and analysed it. Data or notifications were consistently submitted to external organisations as required.

The service analysed data and had the oversight to improve information sharing across local teams. All areas displayed a performance dashboard showing performance and risk information across the maternity services. This was accessible to all people, and staff were informed of changes and were involved in making changes. Since the last inspection, the service had made improvements for staff and leaders to come together via a quality improvement meeting to influence change and improvements. The service submitted the required data returns to all relevant national programmes as required.

There were further improvements to be made to ensure data was split by hospital site.

Engagement

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

We noted there had been a fresh focus on the 'Empowering Voices' agenda, as the service had re-engaged with Maternity and Neonatal Voices Partnership (MVP). We saw positive staff engagement with women and families visiting the service. The workforce was diverse to meet the needs of the population. Leaders had enhanced communication processes with all staff to capture their experiences better to drive improvements.

Maternity

Learning, continuous improvement and innovation

Generally, 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.

Leaders acknowledged the maternity service was on an improvement journey. They had taken many steps to improve the service since the last inspection. Staff we spoke with also felt the service was improving but there was still more to do.

In November 2023, the Trust launched its Perinatal Safety Improvement Programme comprising four workstreams to align with the National Three-Year Maternity and Neonatal Improvement Programme. Actions to address the concerns raised by CQC were assigned to the most relevant workstream to be delivered, with assurance provided to the Perinatal Safety Improvement Programme Group and then to the Maternity Assurance Committee. Action tracking and evidence to support sign-off was filed in a secure online project management tool to which access is provided for all stakeholders.

Staff told us and we saw they were engaged in the improvement areas and they were encouraged to get involved, ask questions and see where improvements had been made. Staff were a part of the change. There were monthly meetings where staff could find out about the changes and ask questions.

A project manager oversaw, and supported the changes required to demonstrate compliance with the section 29A warning notice that we issued after the last inspection.

We saw a service that was making improvements to enhance the quality of care and treatment being provided for women and birthing people.

Outstanding practice

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

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

Maternity

- The trust must ensure that the use of MEOWS is consistently implemented across the service in line with the policy. Reg12 (2) (a).
- The trust must ensure there are always enough suitably qualified and skilled staff on duty. Reg 18 (1)
- The trust must ensure staff report all incidents in line with the incident reporting policy. Reg 12 (2) (b)

Action the trust SHOULD take to improve:

Maternity

- The service should ensure all areas are clean and free form clutter and obstruction across maternity during internal works.
- The service should consider further separation of its maternity data for all sites.

Our inspection team

Emergency and urgent care

The inspection team was made up of a lead CQC inspector a second CQC inspector and a CQC senior specialist. We were accompanied by a senior nurse experienced in emergency care and a doctor who was an emergency medicine consultant acting as specialist advisors.

Maternity

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, 1 obstetric specialist advisor and 2 midwifery specialist advisors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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