Case study: University Hospitals of Leicester NHS Trust

Split site maternity and neonatal services are contributing to staffing deficits, limited patient privacy and lengthening waiting times, potentially impacting on the delivery of safe care at times of high activity.

Introduction

University Hospitals of Leicester NHS Trust is one of the largest and busiest teaching trusts in the UK, serving the estimated one million residents of Leicester, Leicestershire and Rutland.

It also provides specialist services, including nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, ECMO, cancer and renal disorders to a further two to three million patients from across the country.

The trust is spread across three sites: Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and Glenfield Hospital. LRI is located close to Leicester city centre, and provides the only A&E service to the city and surrounding district. LGH is situated three miles east, and the Glenfield Hospital around three miles north west of Leicester City Centre.

The problem

The need to reconfigure Leicester's hospitals to make them both clinically and financially viable dates back nearly two decades. Pressure and has been building across a number of clinical services, including intensive care and renal. The hospital as a whole is rated as 'requires improvement' by Care Quality Commission (CQC), and there is a significant backlog maintenance issue across the whole estate.

Maternity and neonatal services are particularly affected. Having to run services on two sites leads to duplication of facilities and equipment as well as dividing the staff employed by the service in a way that means less effective staffing of one or both units. Generally, the more complex activity is located at the LRI and so staffing, particularly medical staffing is prioritised on this site. At times this can make the LGH site vulnerable if activity is high.

Furthermore, working across sites leads to inefficiencies with staff having to cross sites during working hours to commitments in each of the LRI and LGH Units.

In May 2019, CQC carried out an unannounced inspection at LRI in response to three serious incidents reported between January and April 2019. Concerns have also been raised through the NHS England quality and safety review.

In particular, these investigations highlighted that:

- neo-natal services are currently split across two sites (LGH and LRI)[1], which breaches the British Association of Perinatal Medicine standards for consultant staff[2]

- the physical environment of the maternity unit at LRI does not provide privacy for assessments of women, staff handovers or for staff managing phone calls. The waiting area within the unit is small and cramped[3].

The impact

"If the split site maternity configuration strategy is not enacted, then it may result in a detrimental impact on safety and effectiveness of maternity services at the LGH site leading to potential harm"[4]

Running two sites leaves staff overstretched.
There is a staffing deficit across all sites caused by the split site working. Medical staffing numbers are lower at LGH in order to ensure sufficient cover at LRI. At times, this means a single consultant has to cover the delivery suite, ward and emergencies at LGH.[5] The CQC reported a "lack of consultant presence"[6] within the maternity assessment unit (MAU) at LRI, with junior doctors carrying out assessments and sometimes finding it difficult to obtain opinions from consultants.

Patient experience and privacy is being compromised. Staff report that women are being required to wait up to five hours in a "small and cramped" waiting area in the MAU at the LRI. On 33 occasions between April and May 2019, a woman waited more than four hours in the MAU, and on 11 occasions this wait was for review by a doctor.[7] No reasons were provided for these four hour waits. The waiting area within the MAU is extremely close to the nurse's station – where phones are answered, and staff handovers are undertaken – and to the assessment bays. Privacy is being compromised.

The safety of both women and babies is at risk. There is an up to four week delay in the 12-week growth scan at LRI[8], which risks breaching the NICE clinical guidelines.[9] This is particularly concerning for the combined screening test, which is most effective is carried

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[1] University Hospitals of Leicester NHS Trust (May 2019), *Trust Board Paper H: UHL Reconfiguration Update – Impact of capital delay on costs and clinical sustainability*, p.4
[2] British Association of Perinatal Medicine (2014), *Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing: A Framework for Practice*
[3] Care Quality Commission (August 2019), Leicester Royal Infirmary: Quality Report, p.9
[4] University Hospitals of Leicester NHS Trust (May 2019), *Trust Board Paper H: Integrated Risk and Assurance Report: March 2019*, p.7
[5] University Hospitals of Leicester NHS Trust (May 2019), *Trust Board Paper H: UHL Reconfiguration Update – Impact of capital delay on costs and clinical sustainability*, p.5
[6] Care Quality Commission (August 2019), Leicester Royal Infirmary: Quality Report, p.10
[7] Care Quality Commission (August 2019), Leicester Royal Infirmary: Quality Report, p.10
[8] Care Quality Commission (August 2019), Leicester Royal Infirmary: Quality Report, p.12
[9] NICE (February 2019), Antenatal care for uncomplicated pregnancies

out before the 14th week of pregnancy. Additional scanning clinics and a referral triage system have been put in place to reduce these delays.

The solution

The only medium to long term solution to the challenges facing the trust is a single site maternity and neonatal service at a cost of around £80m, a part of the overall strategy of reconfiguration which requires capital funding of upwards of the £456m originally submitted in July 2018.

If the money is found, quality and clinical outcomes will improve with the separation of elective and emergency care, reduced cancellations and the co-location of appropriate clinical services.

In lieu of capital funding, to mitigate for the split site neonatal unit, the trust has increased consultant presence at LGH. To do so, they are having to establish a resident consultant tier to cover the busier LRI neonatal unit, with a second on call consultant covering LGH and the transport service. However, the trust acknowledges this will not full resolve the issue. Five additional consultant posts will need to be appointed to mitigate the risk and ensure sustainability of the unit until it can be moved, at an estimated annual revenue cost of £600,000.

In addition, the increase in staffing levels being made to reduce the risk of split site working in maternity is estimated to cost around £2m per annum. Other mitigations, including the implementation of a day care service and theatre upgrades, are also being considered, and will have further revenue and capital implications.