

University Hospitals of Leicester NHS Trust

Glenfield Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Medical care (including older people's care)

Good



Surgery

Good



Critical care

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 through the merger of Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary.

The trust provides care to the people of Leicester, Leicestershire and Rutland as well as the surrounding counties. Some of its specialised services provide care and treatment to people from all over the UK.

Glenfield Hospital has 427 inpatient beds and 23 day case beds and provides a range of services for patients, including nationally recognised medical care for heart disease, lung cancer and breast care.

This inspection was a responsive inspection which was designed to look at the improvements the trust had made since the last inspection in January 2014. We inspected Glenfield Hospital between 20- 23 June 2016. We also carried out unannounced inspections to Leicester Royal Infirmary, the Glenfield Hospital and Leicester General Hospital on 27 June, 1 July and 7 July 2016.

Overall we found Glenfield Hospital was performing at a level which led to the judgement of requires improvement. We inspected six core services at this hospital, four were rated as good and two were rated as requiring improvement.

Our key findings were as follows:

- Staffing levels in most areas, were sufficient to deliver safe care
- Essential information and guidance was available for all temporary staff including bank, locum and agency.
- Recruitment and retention was an issue and the trust was currently revising and reviewing its recruitment processes. There had in the past been a recruitment drive for international nurses for critical care, which was reported as being successful.
- The trust had a slightly lower percentage of consultants when compared to the England average. The percentage of junior grade staff was slightly higher than the England average.
- Consultant cover, after 10pm, in all areas was through on-call arrangements only. Out of hours care was provided by a 'hospital at night' team which comprised of junior doctors, nurses and clinical support workers, with all patient-related tasks managed by a senior nurse who triaged the tasks and assigned each to a member of the team.
- When assigned to critical care, consultants had no other clinical responsibilities within the hospital.
- Weekend and out-of-hours on-call advice for staff was provided by a consultant employed by the local hospice. Staff could use this facility to access specialist advice and support if a patient was identified as at the end of life.
- The trainees we spoke with said there was a good balance between work and teaching.
- Glenfield Hospital (GH) participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The assessment of cleanliness for this hospital demonstrated a compliance level of 97%, which was almost equal to the England average of 98%.
- Trust wide there had been 67 cases of clostridium difficile (c. difficile) infections between March 2015 and April 2016 with one case occurring at this hospital in the surgical areas. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between April 2015 and April 2016, there were 15 cases of MRSA with none in the surgical areas at GH.
- All ward areas at GH were screened wards. This meant all patients were tested for MRSA prior to admission. Any patient found to be a carrier of MRSA would be treated before admission. This ensured that all patients requiring surgery at GH were protected from unnecessary harm. Any outlying patients that had not been screened were isolated and treated for MRSA until swabs proved negative. We saw evidence of negative MRSA screen results in all 12 patient records we reviewed.

Summary of findings

- Staff were observed washing their hands appropriately, using cleansing hand gels and wearing personal protective equipment (PPE) such as aprons, gloves and masks. Staff were adhering to the 'bare below the elbows' policy when in clinical areas..
- Without exception, all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- The trust reported 44 serious incidents between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Medical care had the highest number of serious incidents reported at 13 (30%) with one serious incident reported at this hospital.
- Staff reported getting feedback from incidents through email, staff meetings, board 'huddles' and, during handovers. All staff we spoke with were able to tell us of incidents they had reported and of more serious incidents that had occurred on other hospital sites.
- The Glenfield hospital took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results showed the hospital had eight scores better than, and nine scores worse than, the England average. The indicator 'seen by the Multidisciplinary diabetic foot team (MDFT) within 24 hours' was significantly worse than the England average at 28.6% compared to 58% nationally. Results also demonstrated an increase in prescription errors between the 2013 (11.1%) and 2015 (32.8%) audits.
- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient's care and treatment. We saw involvement from nurses, medical staff, allied health professionals (AHP) and specialist nurses. Most staff we spoke with told us that there were good lines of communication and working relationships between the different disciplines.
- Medical records demonstrated an MDT approach to the delivery of patient care. Throughout the care records we reviewed we saw input from for example; physiotherapists, consultants, dieticians, nurses, speech and language therapy (SALT) and specialist nurses.
- MDT meetings took place weekly as a minimum across all medical care wards and units.
- Patients receiving end of life care received support from an end of life care multidisciplinary team (MDT). This included the specialist palliative care team consultants, nursing staff, occupational therapists, physiotherapists, oncologists and other relevant professionals. The chaplain and the bereavement team were also part of the MDT for end of life care patients.
- Quarterly monitoring of dementia training figures were undertaken as part of the National Dementia CQUIN. Dementia awareness training had been developed using a multi-agency approach and focussed on two categories; dementia category A (basic level, required by all employees) and dementia category B (enhanced level, required by staff working clinically with adult patients). Between January 2016 and March 2016 category A training had exceeded the trust target of 90% with 93% of staff having completed this training. For the same reporting period 89% of staff had completed category B training which was slightly lower than the trust target of 90%.
- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. All the staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- Patients were involved as partners in their care and were supported to understand their care needs.
- The trust wide data for June 2016 showed that the majority of specialties met or exceeded the 90% standard of 90% of patients meeting their RTT.
- Senior staff told us they made decisions about whether to cancel operations the day before the operation wherever possible.
- Information from NHS England showed the total number of elective operations in University Hospitals Leicester, (UHL) cancelled on the day between January and June 2016, was 854. All but 92 of these were rescheduled within 28 days.

Summary of findings

- Wards and departments included single-gender accommodation, which promoted privacy and dignity. The trust performance reports from April 2016 showed there were no reported times when male and female patients had been treated in a mixed area at this hospital between March 2015 and April 2016.
- The children's hospital 18 week referral to treatment performance data (June 2015 to May 2016) for admitted and non-admitted performance against each speciality, showed that during the 12 month period the monthly range for admitted performance was between 72.7% (December 2015) and 88.6% (July 2015). This was worse than the England average of 95%.
- Podcasts (a digital audio file made available on the internet) on recognition of the sick child had been produced by a senior member of the medical staff for GPs to use in the community. These were accessible from the university hospitals website and included identifying the sick child, fits, faints and funny turns.
- Most staff we spoke with were able to articulate the trust's vision and the values.
- University Hospitals of Leicester NHS Trust had a detailed five year integrated business plan which covered 2014 to 2019. A two-year 'operational plan' was in place within emergency and specialist medicine with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy.
- There was a detailed business plan for the development and reconfiguration of critical care services across the trust. These included the expansion of critical care beds on the Glenfield site, with the addition of a further 11 beds, to accommodate the increased need for capacity as other services also reconfigured and relocated.
- A separate 'Clinical Vision and Strategy for Children's services 2016' was in place, which identified four strategic goals to provide an age-appropriate service for children and young people with a focus on outstanding, compassionate clinical care.
- Locally, staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support.
- Ward leaders and matrons spoke of ward staff with pride. There was a clear mutual respect amongst staff, ward leaders and matrons.
- Staff felt respected and valued, happy to work at the trust and felt part of their immediate team. We observed staff working as a team on all of the areas we visited and saw high levels of patient engagement.
- On all of the areas we visited staff spoke of patients being the focus of their work. We saw staff consistently delivering care and demonstrating behaviours in line with the trust vision and values.
- The NHS Staff Survey 2015 saw the percentage of staff recommending the trust as a place to work or receive treatment as higher than the 2014 survey at 3.6%. This was slightly lower than the national average of 3.7%.
- In five out of eight questions relating to job satisfaction, the trust scored better than the national average for other NHS trusts 91% of staff felt that their role makes a difference to patients compared to 90% as a national average.
- There was an understanding amongst staff of the implications of duty of candour and we were given examples of where shortfalls in patient experience or care had been shared with relatives in accordance with duty of candour principles.

We saw several areas of outstanding practice including:

- An initiative to improve the timely administration of medicines for Parkinson's disease (PD) had been put in place across the trust and we saw evidence of this in use at the Glenfield hospital. Ward staff told us they were aware of the PD medication stock held on the clinical decision unit (CDU) and this reduced requests for these medicines out of hours and ensured patients received their medicines when needed.
- Patients on the coronary care unit could be monitored remotely using mobile cardiac telemetry (MCT). This meant patients could mobilise whilst undergoing continuous cardiac monitoring.
- A range of medicines to manage Parkinson's disease was available on the Clinical Decisions Unit (CDU) at the Glenfield Hospital. These medicines are time sensitive and delays in administering them may cause significant patient discomfort. These medicines were available to be 'borrowed' by other wards within the hospital and the nurses we spoke with were aware of this facility. The formulations of these medicines may sometimes cause confusion and pharmacy had produced a flowchart to ensure staff selected the correct formulation.

Summary of findings

- A 'pain aid tool' was available for patients who could not talk and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, body language and physical changes to help determine level of patient comfort.
- A comprehensive two-year competency based training programme was in place on the coronary care unit (CCU). Competencies included; intra-aortic balloon pump (an intra-aortic balloon pump is a mechanical device that helps the heart pump blood), continuous positive airway pressure, a treatment that uses mild air pressure to keep the airways open, high flow oxygen and advanced life support
- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.
- The respiratory early discharge scheme (REDs) was in place to speed up hospital discharge for respiratory patients, especially those with chronic obstructive pulmonary disease (COPD). However, there were also areas of poor practice where the trust needs to make improvements.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Importantly, the trust must:

Medicine

- The trust must take action to ensure nursing staff adhere to trust guidelines for the completion and escalation of early warning scores (EWS).
- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas.

Surgery

- The provider must ensure that appropriate systems and training are in place to ensure that Consent forms are completed appropriately for patients who lacked capacity and were made in line with the Mental Capacity Act 2005.

Critical Care

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.

Services for children and young people

- The hospital must improve the numbers of staff on each shift trained in Advanced Paediatric Life Support and European Paediatric Life Support Royal College of Nursing (RCN) 2013 staffing guidance. Training levels for Paediatric Life Support were low so there was insufficient staff who were suitably trained.

End of Life

- The trust must ensure 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms are completed appropriately in accordance with national guidance, best practice and in line with trust policy.
- The trust must ensure there are sufficient numbers of suitable syringe drivers with accepted safety features available to ensure patients would receive safe care and treatment.

Summary of findings

Outpatients and diagnostic imaging

- The trust must ensure FP10 are kept securely and that there is an audit trail of their use.
- The trust must ensure patients' privacy is maintained when tests are being carried out.

In addition the trust should:

- The trust should ensure fire prevention and safety is given sufficient priority at all times.
- The trust should ensure medical staffing on ward 28 is reviewed to maintain appropriate levels of support for junior medical staff.
- The trust should ensure a sufficient number of staff trained as 'scrub assistants' are available on the angio-catheter suite.
- The trust should ensure the referral to treatment times (RTT) for the cancer standard and access to diagnostic tests within six weeks of referral are reviewed with actions in place to improve services.
- The trust should ensure fluid balance charts used to record a patient's fluid intake and output are adequately completed in order to monitor a patient's fluid balance to prevent dehydration or over hydration.
- The trust should consider publicly displaying safety thermometer data in order that patients and the public could see how the ward was performing in relation to patient safety.
- The trust should consider seven-day working for medical staff across the medical specialties
- The trust should ensure that the actions initiated after the recent never event include re-enforcing the importance of the timely reporting of all incidents.
- The trust should consider how it is going to meet the existing areas of non-compliance with the D16 National Service Specification for Adult Intensive care. More specifically, the shortfall in allied health professional support and NICE guidance.
- The trust should consider how it is going to reduce the number of cancelled elective surgery cases.
- The trust should locate, monitor and track the syringe drivers across the trust.
- The trust should review the leadership arrangements and focus on end of life care to ensure it is given sufficient priority at CMG and board level.
- The trust should ensure that cleaning arrangements are adequate, formalised and monitored.
- The trust should minimise in-clinic wait time for patients and check their pain levels
- The trust should train outpatient booking staff in good booking and patient management practices.
- The trust should plan services to meet local need. The trust should ensure that it has access to all necessary information about the service in order to mitigate risks to the quality and safety of treatment
- The trust should implement transparent quality, safety and performance arrangements, for example, consistent use of quality dashboards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Medical care
(including
older
people's
care)**

Rating

Good



Why have we given this rating?

We rated medical care services as good. Safety of medical services was rated as requires improvement. Patients were at risk of not receiving the correct treatment in a timely manner. Nursing staff were not consistently adhering to trust guidelines for the completion and escalation of early warning scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately. Potential risks to medical care services were anticipated and planned for in advance with all staff demonstrating an awareness of the arrangements in place to respond to emergencies and major incidents. There were systems, processes and standard operating procedures in infection prevention control, records, medicines management and maintenance of equipment which were mostly reliable and appropriate to keep patients safe. Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. However, fire safety was not always given sufficient priority. We saw inappropriate storage of medical gases, fire doors held open and store rooms not sufficiently equipped should a fire occur. We rated medical care services as effective, caring and responsive as good. Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment. However, patients were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week. Patient's symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes for patients in endoscopy. Staff were proactive in assessing the patient's nutrition and hydration needs.

Summary of findings

We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was largely positive about the care and treatment they had received.

Medical care services were responsive to patient's needs; patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families. However, referral to treatment times (RTT) for the cancer standards and access to diagnostic tests were worse than the England average.

The leadership of medical care service at this hospital required improvement because governance arrangements did not promote the delivery of high quality person-centred care.

Surgery

Good



We rated surgical care services as good overall but the safety of the service required improvement. Potential risks to surgical care services were anticipated and planned for with all staff demonstrating an awareness of the arrangements in place to respond to emergencies and major incidents.

There were systems, processes and standard operating procedures in infection prevention control, records, and maintenance of equipment, which were mostly reliable and appropriate to keep patients safe.

Patients were protected from abuse; staff had an understanding of how to protect patients from abuse.

Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment.

We saw where patient's symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes. Staff were proactive in assessing the patient's nutrition and hydration needs.

We observed staff positively interacting with patients and patients were treated with kindness,

Summary of findings

dignity, respect and compassion while they received care and treatment. Feedback from patients was positive about the care and treatment they had received.

Surgical care services were responsive to patient's needs; patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families.

The leadership, governance and culture in surgical care services supported the delivery of high quality person-centred care; departmental governance and risk management arrangements were mostly effective and as such able to protect patients from avoidable harm.

Patients were not always protected from avoidable harm. Control of Substances Hazardous to Health (COSHH) was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. Cleaning fluids were not always stored in locked cabinets.

Systems and processes are not always reliable or appropriate to keep people safe. Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments completed in a timely manner or reviewed after 24 hours.

Monitoring and audit of safety systems was not robust. There was no effective audit for the World Health Organisation (WHO) five steps to safer surgery checklists.

Critical care

Good



Overall we rated the critical care service as good. There were sufficient numbers of suitably qualified staff to care for patients. We found a culture where incident reporting was encouraged and understood by staff. There was strong clinical and managerial leadership at both unit and management group level and the service had a vision and strategy for the future. There was an effective governance structure in place which ensured that the risks to the service were known, recorded and discussed. The framework also enabled the dissemination of shared learning and service improvements.

Summary of findings

Patients and their relatives were cared for in a supportive and sympathetic manner and were also treated with dignity and respect. However, There were some issues with access and flow. In 2015, 21 patients had their elective surgery cancelled. The critical care unit did not achieve the intensive care core standard (ICS) of 50% of staff having a post registration course in critical care, 29% of staff had completed this.

Services for children and young people

Good



We rated the children's and young people's service as good overall because there was a positive incident reporting culture. Staff knew how to report incidents and gave examples of when they had done so. There was appropriate incident investigation with actions and learning shared amongst staff. Staff adhered to trust infection prevention and control policies and we saw staff using hand sanitiser between patient contacts. All equipment including resuscitation equipment had been tested and checked regularly. Escalation plans were available for the Children's Hospital, paediatric intensive care and the ECMO Unit. Staff conducted nursing handovers called 'safety huddles' to ensure all staff had up to date information about patients. Staff discussed new and existing patients, their medical history and care plans highlighting any key information including potential risks to patients. Medicines management was mainly in line with trust policy.

We observed positive, compassionate care and staff were sensitive to the needs of babies, children, young people and those close to them. Without exception, patients and those close to them were positive about their care and treatment. Patients felt involved in their care and treatment. Staff communicated in ways, which enabled patients and those close to them to understand what was happening.

The hospital provided specialist services for patients, including the Congenital Heart Centre and extracorporeal membrane oxygenation (ECMO) care. Staff met patient's individual needs and could access specialist support such as interpretation, spiritual support and specialist nurses.

Summary of findings

Staff assessed and responded to pain appropriately therefore patients had timely access to pain relief. Staff had access to a children's pain team who performed daily ward rounds.

Services for Children and Young people conducted audits to monitor patient outcomes. The majority of the results of these audits were positive or showed improvement.

There was a clear vision and strategy for the service. There was a positive and open culture and staff were proud to work at the hospital. Leaders were visible and they engaged and listened to staff. We saw positive examples of innovation to improve services delivered.

However;

There were shortfalls regarding the numbers of staff training in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS). The service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance.

The service did not meet the trust target of 95% for all subjects covered under mandatory training for both medical and nursing staff.

End of life care

Requires improvement



Overall, we rated end of life care services as requires improvement.

The medical staff levels were not in line with the recommendations from the National Council for Palliative Care who recommend that there is one whole time equivalent (WTE) consultant for every 250 beds. The service had 3.5 WTE and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended. The trust had 82 syringe drivers that were in line with best practice guidelines. However, only ten were ready for use. This meant another syringe driver was being used instead, which did not meet the NHS patient safety guidance.

Out of 25 'Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR), nine were completed correctly (38%).

Summary of findings

The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust scored lower than the England average for all five Clinical KPIs.

The trust had undertaken an audit in April 2016 in response to the National Care of the Dying Audit 2016, and an action plan had been developed to address the KPIs that had not been achieved.

There was no strategic plan for end of life care throughout the trust and there was no non-executive director representing end of life care at board level.

We found care records were mostly maintained in line with trust policy. Staff understood their responsibilities in following safeguarding procedures.

Care and treatment was delivered in line with recognised guidance and evidence based practice.

The last days of life care plan was in use throughout the trust.

Outpatients and diagnostic imaging

Requires improvement



Overall we rated Glenfield Hospital Outpatient and Diagnostic Imaging services as requires improvement.

There were outpatient delays and cancellations across the trust. Some people were not able to access services for assessment, diagnosis and treatment when they needed to. The trust recognised this but arrangements to match future capacity to demand were not in place. Governance arrangements for better waiting list management were in development

Some arrangements lacked controls to keep patients safe. Fridge temperatures for medicines were not safely monitored but this was rectified during our inspection.

There was no audit process or record of the use of some FP10 prescription pads, which was a risk that the prescription issuing process could be abused.

The trust had not implemented and audited use of the WHO safety checklist across the trust.

Patient dignity was compromised in some areas.

Some reception arrangements, for example diagnostic imaging reception, were not conducive to

Summary of findings

privacy or confidentiality. The 'shuttle walk' test, which formed part of the cardiac rehabilitation programme, was not performed in a location that respected dignity or privacy of patients.

Leadership for outpatient services was fragmented. Risks, issues and poor performance were not always dealt with appropriately or in a timely way, and this meant patients sometimes had long waits for new or follow up appointments and experienced in-clinic delays.

However, staff understood and fulfilled their responsibilities to raise safety concerns and report incidents and near misses; managers supported them when they did. If something went wrong, there was a thorough review or investigation involving all relevant staff and people who used services. Lessons were learned and communicated widely. Equipment checks were up to date and clinical areas were clean on the day we inspected. Staff had a good knowledge of safeguarding and the Mental Capacity Act or knew who they could go to for expertise. They knew what to do if a patient's health started to deteriorate.

Diagnostic imaging services learned from incidents and improved safety. They used diagnostic reference levels to check dosage and had a range of safety related policies which staff understood and used.

Imaging services were available seven days a week. GPs could refer patients to Glenfield for diagnostic imaging procedures with a 48 hour turnaround.

Patients, those who were close to them and stakeholders gave positive feedback about the way staff treated people. Glenfield based specialties had high 'would recommend' scores from patients.

Patients we spoke with were happy with their care and spoke highly of staff at Glenfield hospital.

Care was planned and delivered in line with current evidence-based guidance. Examples of good practice included the Rapid Access Heart Failure Clinic. The services used local and national audit arrangements to maintain the effectiveness of treatment. Clinicians worked effectively in multidisciplinary teams to find solutions for complex patients. There were one-stop clinics in breast care and pulmonary embolism ambulatory clinic This meant patients could discuss a range of related

Summary of findings

issues on the same visit to the hospital. There was a positive working culture at Glenfield, and innovative practices, particularly in cardiac and respiratory rehabilitation.

Glenfield Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Detailed findings

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Background to Glenfield Hospital

Glenfield Hospital is about three miles north west of Leicester city centre. The hospital has approximately 415 beds and provides a range of services for patients, including nationally recognised medical care for heart disease, lung cancer and breast care.

The hospital is part of The University Hospitals of Leicester NHS Trust which is made up of three main hospital sites.

Our inspection team

Our inspection team was led by:

Chair: Judith Gillow, Non-Executive Director of an Acute Trust and Senior Nurse advisor to Health Education Wessex.

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a consultant surgeon, a medical consultant, registered nurses, allied health professionals, midwives and junior doctors.

We were also supported by two experts by experience who had personal experience of using, or caring for someone who used the type of service we were inspecting.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before our inspection, we reviewed a wide range of information about University Hospitals of Leicester NHS Trust and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, National Health Service Intelligence (NHSI), Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

Detailed findings

The announced inspection took place between the 20 and 23 June 2016. We held focus groups with a range of staff throughout the trust, including, nurses, midwives, junior and middle grade doctors, consultants, administrative and clerical staff, physiotherapists and occupational therapists, porters and ancillary staff. We also spoke with staff individually.

We also carried out unannounced inspections to Leicester Royal Infirmary, the Glenfield Hospital and Leicester General Hospital on 27 June, 1 July and 7 July 2016. We also spoke with patients and members of the public as part of our inspection.

Facts and data about Glenfield Hospital

University Hospitals of Leicester NHS Trust is a teaching trust that was formed in April 2000 following the merger of Leicester General Hospital, the Glenfield Hospital and Leicester General Hospital. The trust has 1,784 inpatient beds and 175 day-case beds. 407 inpatient beds and 23 day-case beds are located at Glenfield Hospital.

University Hospitals of Leicester NHS Trust provide specialist and acute services to a population of one million patients throughout Leicester, Leicestershire and Rutland.

The trust employs 12,690 full time equivalent staff members. 1,814 of which accounted for medical staff, 4,244 accounted for nursing staff and 6,632 accounted for other staff.

The trust has total revenue of £865,841 million and its full costs were £899,940 million. It had a deficit of £34,100 million.

There were 149,806 inpatient admissions, 993,617 outpatient attendances and 135,111 emergency department attendances between April 2015 and March 2016.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Outstanding	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Detailed findings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Medical care (including older people's care)

Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

University Hospitals of Leicester NHS Trust provides medical care (including older people's care) at this hospital as part of three clinical management groups (CMGs): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS), and renal, respiratory and cardiovascular. Specialties include: Gastroenterology, cardiology and respiratory medicine.

The trust has 902 inpatient medical beds across the three sites; 293 inpatient beds and 18 day case are located within 15 clinical areas at Glenfield Hospital. During our announced and unannounced inspection of this hospital we visited 12 clinical areas. These included; wards 15, 16, 17, 17H, 20, 27, 28, 29, 32, the discharge lounge, coronary care unit and the angio-catheter suite.

Glenfield Hospital had 31,500 medical episodes between September 2014 and August 2015. Emergency admissions accounted for 58%, 35% were day case, and the remaining 6% were planned admissions. A total of 47% of admissions were in respiratory medicine, 28% cardiology and 25% gastroenterology.

The Clinical Decisions Unit (CDU) at the Glenfield Hospital also provided services for patients who present with cardiac and respiratory conditions. The CDU provided a 24-hour service seven days a week. Our visit to this unit is included as part of the medicine report.

During our inspection of this hospital we spoke with 13 patients, two relatives and 27 staff. Staff we spoke with

included junior and senior registered nurses, health care assistants, housekeeping staff, student nurses, nurse endoscopists, allied health professionals, a radiographer and junior and senior medical staff.

As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of patients who could not speak with us. We observed interactions between staff, patients, and patient's relatives, considered the environment and looked at nine medical and nursing care records and 13 patient observation / sepsis screening pathways. Before our inspection, we reviewed performance information from, and about the trust.

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Summary of findings

We rated medical care services as good.

We rated safe as requires improvement and effective, caring, responsive and well led as good because:

- Patients were at risk of not receiving the correct treatment in a timely manner. Nursing staff were not consistently adhering to trust guidelines for the completion and escalation of early warning scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated. Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately.
- Fire safety was not always given sufficient priority. We saw inappropriate storage of medical gases, fire doors held open and store rooms not sufficiently equipped should a fire occur.
- Patients were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week.
- Referral to treatment times (RTT) for the cancer standards and access to diagnostic tests were worse than the England average.
- Governance arrangements did not promote the delivery of high quality person-centred care.

However:

- Potential risks to medical care services were anticipated and planned for in advance with all staff demonstrating an awareness of the arrangements in place to respond to emergencies and major incidents.
- There were systems, processes and standard operating procedures in infection prevention control, records, medicines management and maintenance of equipment which were mostly reliable and appropriate to keep patients safe.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse.

- Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment.
- Patient's symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes for patients in endoscopy.
- Staff were proactive in assessing the patient's nutrition and hydration needs.
- We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was largely positive about the care and treatment they had received.
- Patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We rated safety of medical services as requires improvement because there was limited assurance about safety.

We found:

- Potential risks to medical care services were anticipated and planned for in advance with all staff demonstrating an awareness of the arrangements in place to respond to emergencies and major incidents.
- There were systems, processes and standard operating procedures in infection prevention control, records, medicines management and maintenance of equipment which were mostly reliable and appropriate to keep patients safe.
- Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment.
- Patient's symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes for patients in endoscopy.
- Staff were proactive in assessing the patient's nutrition and hydration needs.
- We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was largely positive about the care and treatment they had received.
- Patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and could demonstrate where changes to practice had been made as a result.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. Staff were able to describe what safeguarding was and the process to refer concerns.

- Systems, processes and standard operating procedures in records, medicines management and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- Nursing and medical staff were up to date in mandatory training and levels of staffing and skill mix of nursing staff were managed appropriately with the use of bank and agency. An effective induction process was in place for locum, agency and bank staff. This ensured patient's safety.

However we also found;

- Patients were not always protected from avoidable harm. Nursing staff did not always adhere to trust guidelines for the completion and escalation of early warning scores (EWS), the frequency of observations were not always appropriately recorded on the observations charts and medical staff had not always documented a clear plan of treatment if a patient's condition had deteriorated.
- Where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of not receiving the correct treatment in a timely manner.
- Infection control was not always given sufficient priority. Hand hygiene audit results were low, staff were not consistent in isolating patients at risk of spreading infection to others and the quiet room on ward 17 was carpeted.
- Fire safety was not given sufficient priority at all times. We saw inappropriate storage of medical gases, fire doors held open and store rooms not sufficiently equipped should a fire occur.
- Medical staffing on ward 28 had been raised as a concern by nursing staff including the matron of the service.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents were reported through the trust's electronic reporting system.
- Without exception, all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- There were no never events in this service between March 2015 and March 2016. Never events are serious

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incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.

- The trust reported 44 serious incidents between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Medical care had the highest number of serious incidents reported at 13 (30%) with one serious incident reported at this hospital.
- The serious incident related to a power failure at the Glenfield Hospital. We reviewed the full investigation report for this incident. The investigation report was thorough and showed a robust review had taken place and relevant staff were involved in the review or investigation. The investigation report showed there was no duty of candour requirement.
- Medical services at this hospital reported 1924 incidents from March 2015 to March 2016. Of these, none resulted in major harm, 21 in moderate harm, 299 in minor harm and the majority, 1604 in no harm or injury. Of the 1924 incidents, 40 were reported as near misses. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so.
- The most frequently reported incident categories were 'slips, trips, falls and collisions where 399 incidents were reported and 'Implementation or on-going monitoring of care' accounted for 392 incidents.
- Staff reported getting feedback from incidents through email, staff meetings, board 'huddles' and, during handovers. All staff we spoke with were able to tell us of incidents they had reported and of more serious incidents that had occurred on other hospital sites. Staff gave examples of incidents where they had received feedback. For example, a patient fall, a drug error and pressure damage.
- Mortality and morbidity meetings were held quarterly, as a minimum, across all medical specialties to discuss patient deaths. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be

any shared learning. Minutes we reviewed from meetings held for example, within respiratory medicine and, cardiology showed individual mortality reviews had taken place with evidence of shared learning and actions identified, where appropriate.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with had a good understanding about duty of candour. Staff talked of being open and transparent with the public.
- We saw examples of where duty of candour had been applied appropriately. An open and honest approach had been recorded when a patient had fallen and when an x-ray had been performed on the wrong patient.
- Prior to our inspection we asked the trust if they monitored the application of duty of candour to gain assurance that this process was consistently followed across all areas. Data received following our inspection showed for the reporting period April 2015 to March 2016, there had been no breaches of the duty of candour requirement.
- A member of staff from the clinical decisions unit shared with us the lessons learned and the actions taken following a recent serious incident in which a patient developed a grade four pressure ulcer.

Safety thermometer

- The hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas for example, falls with harms, catheter associated urinary tract infections, pressure damage and venous thromboembolism (VTE). VTE is the formation of blood clots in the vein.
- Data for 13 medical wards from April 2015 to March 2016 showed an average harm free care rate of 96%, which was the same as the hospital average of 96%.
- Safety thermometer data was not publicly displayed on any of the wards or clinical areas we visited. This meant patients and the public could not see how the ward was performing in relation to patient safety. Nursing staff told us it had been a trust decision not to display this data. Wards were told the emphasis was on the 'you said, we did' boards.

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Cleanliness, infection control and hygiene

- Glenfield Hospital participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE are a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 97.1% which was marginally worse than the England average of 98.1%.
- Trust wide there were 65 cases of clostridium difficile (c. difficile) infections between March 2015 and April 2016 with two cases occurring in the division of medicine. C. difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Trust wide between March 2015 and April 2016 there were 11 cases of MRSA reported at this trust with one case occurring in the division of medicine at this hospital.
- Meticillin-sensitive Staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Trust wide between March 2015 and April 2016 there were 27 recorded cases of MSSA at this trust, of which five occurred within the division of medicine at this hospital.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits against key policies. For example; hand hygiene, sharps safety and availability and appropriate use of personal protective equipment (PPE). Following our inspection we asked the trust for any actions taken as a result of these audits. The trust response was there was no evidence of actions taken in result of audits.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for December 2015 for two elements of the audit; before patient contact and, after patient contact demonstrated 62% and 72% compliance respectively across 12 clinical areas. This was better than the trusts overall compliance figures but worse than the trust target of 90%.
- Throughout medical services we observed the majority of staff to be complying with best practice regarding to infection prevention and control policies. All staff were observed to wash their hands or use hand sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons.
- We saw good use of 'I am clean' stickers in ward areas to indicate where staff had signed to say equipment had been cleaned and was ready for patient use.
- Staff were not consistent in isolating patients at risk of spreading infection to others. On ward 16 we saw a door left open to a side room where it had been identified the patient might present an infection control risk to others. We could not see where a risk assessment had been undertaken; we raised this with staff on the ward to determine if a risk assessment had been carried out. The nurse in charge confirmed a risk assessment should have been completed. However, we observed doors closed to five other side rooms where it had been identified the patient might present an infection control risk to others.
- Ward 17 had three side rooms available with negative pressure airflow control. Negative room pressure is used to prevent cross-contaminations from room to room. It includes a ventilation system that generates negative pressure to allow air to flow into the room but not escape from the room, thereby preventing contaminated air from escaping the room.
- The quiet room on ward 17 was carpeted. Staff told us this room was used by patients, relatives and staff but that no clinical care was delivered in this room. We noted the carpet was stained. HBN 00-09 Infection control in the built environment states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets should not be used.
- Precautions were taken in endoscopy when seeing people with suspected communicable diseases or patients at risk of spreading infection to others. Information received following our inspection stated these patients would receive their procedure at the end of a list.

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Environment and equipment

- We checked the resuscitation equipment on four ward areas. The resuscitation equipment on the wards was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence, on the wards that the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- We observed 24 items of patient-care equipment. With the exception of two items of equipment the rest were observed to be clean and ready for use. Patient equipment had been routinely checked for safety with visible safety tested stickers demonstrating when the equipment was next due for service.
- Patients had access to pressure-relieving equipment. None of the staff we spoke with raised concerns regarding the provision and access to patient-care equipment.
- On ward 17 we saw six oxygen cylinders stored on the floor in the clinical area. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored in a purpose-built trolley in a well-ventilated storage area and cylinders should be chained or clamped to prevent them from falling over.
- On ward 27 we saw where oxygen cylinders had been used to hold open doors to two store rooms. In one store room we found seven oxygen cylinders. There was no signage on the door to indicate the storage of oxygen in this area. Medical gases Health Technical Memorandum 02-01 (HTM02) guidance states warning notices should be posted prohibiting smoking and naked lights within the vicinity of the store.
- On ward 27 we did not feel fire safety was considered a priority. We saw two doors where there was either no intumescent seals or the seal was perished. Intumescent fire seals expand in the event of a fire and seal off the gap between the door and the frame. Both doors were to store rooms where consumables, including combustible materials were stored. We raised our concerns immediately with the matron responsible for this area.
- In January 2015, the Department of Health issued an alert to NHS trusts requiring action to reduce the risk of strangulation in children and vulnerable adults from

loop cords and chains on window blinds. During our inspection visit we noted a light switch cord on ward 20 that was not anti-ligature. We raised this immediately with the nurse in charge for this area.

Medicines

- A paper based medicine administration record chart was in use at this site. A pharmacist visited all wards each weekday and there were arrangements in place to contact pharmacists for advice and to obtain medicines out of hours. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the medication administration charts to help guide staff in the safe administration of medicines.
- There were local microbiology protocols for the administration of antibiotics and we saw where these were followed. An antimicrobial pharmacist was also available to offer support and guidance.
- We looked at the prescription and medicine administration records for 16 patients across four wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them. If patients were allergic to any medicines this was recorded on their chart. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- Medicines, including intravenous (IV) fluids were mostly stored securely and we saw controlled drugs were stored and managed appropriately. We did not see records to assure us that medicines requiring refrigerated storage were stored at the correct temperature to ensure they would be fit for use. This was addressed during our inspection and we saw evidence of new paperwork in use on some wards at the Glenfield hospital. However, on ward 16 we found two unlocked cupboards in the treatment room, both contained medicines. We also found a medicines trolley that was not secured to a wall.
- An initiative to improve the timely administration of medicines for Parkinson's disease (PD) had been implemented across the trust and we saw evidence of this in use at Glenfield hospital. Ward staff told us they

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were aware of the PD medication stock held on the clinical decision unit (CDU) and this reduced requests for these medicines out of hours and ensured patients received their medicines when needed.

Records

- During our inspection we reviewed nine medical and nursing care records and, 13 patient observation / sepsis screening pathways. Records were paper-based and held at the patient's bedside and, in notes trolleys in the main ward corridors. We observed notes trolleys were stored securely and were in an area where they could be seen at all times by a member of trust staff.
- On the discharge lounge although patient records were not stored securely we observed this area to be a highly visible area with a number of nursing staff present at all times.
- Records were mostly legible, accurately completed and up to date. Nursing care records included care plans for; breathing and circulation, pain, communication, pressure area / wound care, mobility, elimination and continence, nutrition and fluid balance, personal hygiene, rest and sleep, psychological and emotional well-being, promoting health and safe care and discharge. However care records were not always completed or updated appropriately. For example, on ward 20 a safety checklist had not been completed for six hours. We brought this to the attention of the ward sister at the time of inspection.
- Patient records were multidisciplinary and entries were made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists (SALT) and, dietitians.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. All staff we spoke of were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads.
- Information received after our inspection showed as of June 2016 training compliance in safeguarding children was 98% and, safeguarding adults 99%. None of the staff we spoke with were able to tell us the level of training they had received. All staff thought the level of safeguarding training was pre-determined dependent on their role.

- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.
- Arrangements were in place to safeguard women or children with, or at risk of, female genital mutilation (FGM). Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (level one and two), conflict resolution, safeguarding adults (level one), health and safety, basic life support. Consent, mental capacity act (MCA) and deprivation of liberties safeguards (DoLS) are required to be completed by all clinical staff who have direct clinical contact with patients. This training must also be completed by all Duty Managers, In House Security Staff and On-call Managers.
- Information received after our inspection showed as at June 2016 training compliance in medical services was greater than 90% across all subject areas except basic life support where the compliance rate was 88%. The trust target for mandatory training was 95%, however the data was not split into specific staff groups.

Assessing and responding to patient risk

- Nursing staff used an early warning scoring system (EWS), based on the national early warning score, to record routine physiological observations such as blood pressure, temperature, and heart rate. EWS was used to monitor patients and to prompt support from medical staff when required.
- Patients with a suspected infection or an EWS of three or more, or those for whom staff or relatives had expressed concern were screened for sepsis, a severe infection which spreads in the bloodstream, using an 'Adult Sepsis Screening and Immediate Action Tool'.
- Patients being treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of 'basic'

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aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour.

- During our inspection of this hospital we reviewed 13 patient observation charts across three clinical areas. We found nursing staff did not always adhere to trust guidelines for the completion and escalation of EWS, frequencies of observations were not always appropriately recorded on the observations charts and, medical staff did not always make clear plans for patients in relation to physiological parameters on the EWS chart.
- Frequency of observations was consistently recorded in four out of 13 observation charts. Five out of 13 observation charts had full observations recorded including; blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output (where applicable). Three charts did not have urine output recorded at all (two on ward 15 and one on ward 17) and five charts did not have urine output recorded consistently on each occasion when a EWS was calculated (wards 17 and 27).
- EWS had been completed at each time of recording the patient's observations in 12 out of 13 charts we reviewed.
- EWS scores had been calculated correctly in all of the charts we reviewed with the exception of eight charts (one on ward 15, five on ward 17 and two on ward 27) where urine output was not recorded.
- None of the charts we reviewed had a documented agreement not to escalate if a patient had triggered on their EWS. This should be written by the medical staff and allows nursing staff to make decisions about escalating deteriorating patients. Where agreements were not in place EWS scoring did not always take place in line with trust policy.
- Patients triggering on their EWS were required to have further set of observations recorded within a set timescale for example from four hourly to hourly. Of the 13 charts we reviewed nine patients had not had observations repeated in line with the trust escalation of EWS monitoring in adult patients. This increased the risk of further deterioration for these patients.
- On ward 15 we saw a patient had triggered an EWS of seven at 11.20am on 30 June 2016, a repeat check of the patient's blood pressure was done at 11:25 and the

patient was reviewed by a junior doctor at 11:30. Observations were then not recorded until 1pm where a EWS of seven was recorded. There was no further evidence to suggest that the trust's response to clinical deterioration policy had been followed nor were they screened for sepsis. The trust's sepsis pathway states that patients scoring a EWS of three or above should be screened for sepsis. We raised this immediately with the nurse in charge for this ward who told us medical staff had considered a sepsis screen but not thought it necessary. This was not documented in either the nursing or medical notes.

- On ward 15 we saw a patient had triggered an EWS of seven at 3pm on 29 June 2016. A further set of observations was not recorded until 5pm the same day where an EWS of five was recorded, this was against trust's response to clinical deterioration policy; there was not a documented agreement not to escalate if a patient had triggered on their EWS. The trust's response to clinical deterioration policy had not been followed nor were they screened for sepsis in line with the sepsis pathway.
- On ward 15 we saw a patient had triggered an EWS of six at 8pm on 28 June 2016. A further set of observations was recorded at 8.20pm where an EWS of two was recorded, no further observations were recorded until 6.50am the following day. This was against trust's response to clinical deterioration policy; there was not a documented agreement not to escalate if a patient had triggered on their EWS. The trust's response to clinical deterioration policy had not been followed nor were they screened for sepsis in line with the sepsis pathway.
- On ward 27 we saw a patient had scored a EWS of four at 1:10pm on 28 June 2016, this patient had a systolic blood pressure of 82mmHg. Systolic blood pressure, measures the pressure in your blood vessels when your heart beats. In line with the trust 'Adult Sepsis Screening and Immediate Action Tool', a blood pressure of this level would indicate 'Red Flag Sepsis'. The trust defines 'Red Flag Sepsis' as a time critical condition requiring immediate action. A further set of observations was not recorded until 3pm and we could not see where the patient had received a medical review. This was against trust's response to clinical deterioration policy; there was not a documented agreement not to escalate if a

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patient had triggered on their EWS. The trust's response to clinical deterioration policy had not been followed nor were they screened for sepsis in line with the sepsis pathway.

- On ward 15 we saw that a patient had scored a EWS of three at 2pm on 29 June 2016, a further set of observations should have been recorded within one hour, we saw where the heart rate was recorded at 2:30pm but the EWS was not calculated. The patient had observations recorded again at 8:50pm, this was against trust's response to clinical deterioration policy; there was not a documented agreement not to escalate if a patient had triggered on their EWS. The trust's response to clinical deterioration policy had not been followed nor were they screened for sepsis in line with the sepsis pathway.
- On ward 27 we saw that a patient had triggered an EWS of two at 9pm on 28 June 2016, a further set of observations should have been recorded within one hour. The patient had observations recorded again at 6:30am the following morning, this was not in line with the trust's response to clinical deterioration policy.
- On ward 17 we saw that a patient had triggered a EWS of two at 7:55pm on 29 June 2016, a further set of observations should have been recorded within one hour. The patient had observations recorded again at 5:55am the following morning, this was not in line with the trust's response to clinical deterioration policy.
- Across seven observation charts there were 21 occasions where an EWS of one had been recorded and observations had not been repeated within an hour.
- On ward 17 we saw a patient scoring an EWS of seven at 2:50pm on 29 June. This patient had all the appropriate interventions carried out in line with the trust's clinical deterioration interventions policy, this included specific patient parameters and screening for sepsis in line with the sepsis pathway had been considered.
- Compliance with EWS scoring and escalation was incorporated into the clinical management groups (CMGs) nursing metrics data. We reviewed the nursing metrics data specifically for nine medical wards at this hospital. Data from September 2015 to February 2016 demonstrated an overall average compliance score of 91.6%. This was similar to the overall average compliance score for all medical wards which was 92%.
- Following the inspection, we asked the trust to provide more information about their plans to improve performance on the management of deteriorating

patients as well as sepsis. The trust had a plan in place to improve their performance and they voluntarily offered to report this to us every week. We were satisfied they had adequate plans and governance processes in place to monitor and act on their data.

- At the beginning of October 2016 the trust had 95% of patients who had an EWS score of 0-2 and were appropriately managed; 90% of patients with an EWS of 3 or more were appropriately managed. Ninety two percent of patients with an EWS of 3 or more were appropriately screened for sepsis. The percentage of patients with red flag sepsis who received antibiotics within one hour was 46%.
- A critical care outreach team (CCOT) was available to the wards 24 hours a day, seven days a week. The team supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.
- As patients had been assessed as fit for discharge observations were not routinely recorded in the discharge lounge however, there was continual direct observation and blood glucose checks were maintained where appropriate. Patient's risk of pressure damage continued to be monitored and managed whilst they remained on the discharge lounge.
- Patients requiring non-invasive ventilation (NIV) were nursed on the clinical decision unit in the 'acute' phase of this treatment. Non-invasive ventilation (NIV) refers to the provision of ventilator support through the patient's upper airway using a mask or similar device. Once transferred to the ward patients would usually remain on NIV for a period of 24 to 48 hours before weaning commenced. Weaning refers to the gradual reduction of the length of time patients are requiring NIV. On-site access to levels two and three critical care (intensive care units with full ventilator support) was available at this hospital.
- Staff in the cardiac catheter laboratory used a document based on the World Health Organisation (WHO) safety procedures: WHO surgical safety checklist to ensure each stage of the patient's journey was managed safely.

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Nursing staffing

- Across UHL since September 2014 all clinical areas had collected patient acuity and dependency data utilising the Association of the United Kingdom University Hospitals (AUKUH) collection tool. The AUKUH acuity model is the recognised and endorsed model by the Chief Nursing Officer for England. It is important to note that this tool is only applicable to acute adult ward areas. Acuity means the level of seriousness of the condition of a patient. The patient acuity and dependency scores were collected electronically. The data was considered alongside staffing information from the electronic rostering system and patient information including admissions and discharges and additional tasks undertaken in different clinical areas
- Staffing levels were displayed in all the clinical areas we visited and we saw where information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were 'gaps' in staffing bank and agency staff had been requested.
- During our inspection we observed staffing levels in most areas to be sufficient to deliver safe care. However, during our unannounced visit to the hospital the level of patient acuity on ward 16 was noted to be high. As a result, we saw where extra staff including the nurse in charge, a matron and two health care assistants from another ward area were providing additional support on the ward.
- During our inspection we were told of vacancies on wards 16 (two whole time equivalents) and ward 17 (six whole time equivalents) as a result, a decision had been made to rotate two staff from ward 16 to ward 17 whilst recruitment was under way. We spoke with five staff on ward 17 who all raised concerns around staffing levels.
- In addition to rotating staff from ward 16 we were told of a process to 'block book' bank nurses for a period of time to ensure continuity of care within the ward area. Ward staff were also offered extra hours and/or overtime.
- On ward 17H there was a four-bedded 'High Dependency Unit' for those patients deemed as requiring 'level one' and 'level two' care. Level two care is defined by the Guidelines for Provision of Intensive Care Services (GPICS) as; patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.

GPICS standards suggest 'level 2' patients require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care. Whilst these services were not led by a consultant intensivist and did not therefore have to meet GPICS we observed staffing levels in line with GPICS guidelines.

- The coronary care unit was staffed with a minimum of two band six senior nurses overnight.
- Planned nursing staffing levels across the 15 clinical areas totalled 351.9 whole time equivalents (wte). Data for March 2016 showed actual staffing levels to be 311.2 wte giving a combined vacancy rate of 11.6%. Vacancies varied across clinical areas with vacancy figures of between 0 wte and 7.1 wte. The top three areas with the highest vacancy rates were; CDU (7.1 wte) endoscopy (5.9 wte) and coronary care unit (4.9 wte).
- The average nursing agency usage for April 2015 to March 2016 across medicine was noted to be between 0.8% and 8.7%. Respiratory Medicine for April 2015 to March 2016 requested 208,936 hours of temporary staff, and used 3,926 agency hours which equated to 1.9% across the same reporting period. Agency staffing was managed on a day to day basis with agency use 'shared out' across clinical management groups to mitigate the risk of high numbers of agency staff in any one ward area.
- Essential information and guidance was available for all temporary staff including bank, locum and agency. A specific induction folder was used in the clinical areas for locum staff; 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration.

Medical staffing

- The trust had a slightly lower percentage of consultants when compared to the England average. The percentage of junior grade staff was slightly higher than the England average.
- Medical staffing in cardiology, was provided by two consultants, a locum specialist registrar (SpR) and two junior medical staff. Nursing staff raised concerns with us regarding the numbers and availability of medical staff on ward 28, staff felt these concerns had not been recognised by the senior team within the clinical management group.
- In respiratory medicine day to day cover Monday to Friday was provided by a team of junior, middle-grade

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and senior doctors with overall responsibility provided by a respiratory consultant. Two respiratory consultants and a third consultant provided rotating cover. Out of Hours cover was provided by two junior doctors and a specialist registrar (SpR), with on-call support as per rota. A specialist registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant. Medical staffing on ward 28 is provided by 2 consultants plus a 3rd consultant via a consultant of the week model (3 consultants rotating)

- Consultant cover, after 10pm, in all areas was through on-call arrangements only. Out of hours care was provided by a 'hospital at night' team which comprised of junior doctors, nurses and clinical support workers, with all patient-related tasks managed by a senior nurse who triaged the tasks and assigned each to a member of the team.
- The discharge lounge was a nurse-led unit. Medical cover, if required, was obtained through the trust electronic communication system.
- There were medical vacancies across three areas at this hospital. Data for March 2016 showed vacancies between 2% (cardiology) and 50% (gastroenterology) with an average vacancy rate of 18.6% across all three areas.
- The average medical locum usage for April 2015 to March 2016 across medicine was noted to be between 1% (gastroenterology) and 7.2% (respiratory medicine).
- Essential information and guidance was available for all temporary staff including bank, locum and agency. A specific induction folder was used in the clinical areas for locum staff; 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration.

Major incident awareness and training

- Evacuation training was included as part of fire safety training. Compliance in this training across all staff groups was 94%.
- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident.
- We talked to six nursing staff across five ward areas specifically about their understanding of an emergency

or major incident that may affect services at this hospital. All the staff we spoke with were aware of the trust major incident and business continuity plans and were able to locate them for us. All the staff were aware of the availability of a 'back-up' phone system should the current system fail as a result of a power failure.

- On wards 17 and 20 we saw where relevant major incident plans were displayed in the clinical areas.

Are medical care services effective?

Good



We rated the effectiveness of medical care services as good because patients had good outcomes and received effective care and treatment that met their needs.

We found:

- Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to National Institute for Health and Care Excellence (NICE) quality standards.
- Patient's symptoms of pain were mostly managed effectively in both ward and department areas with good comfort outcomes for patients in endoscopy. Staff were mostly proactive in assessing patient's nutrition and hydration needs.
- Evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively and staff were supported to maintain and further develop their professional skills and experience.
- Outcomes for patients were mostly similar to or above expectations when compared with similar services.

However we also found:

- There was not always consultant presence seven days a week for coronary care. Neither were patients routinely reviewed by a consultant at a weekend unless their condition had deteriorated.
- Scrub assistants were not currently in place on the angio-catheter suite. Scrub assistants handle all instruments, supplies and equipment in the procedure

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room. A formal recommendation of the British Cardiology Interventional Society (BCIS) is that a scrubbed assistant should be present at all times to achieve optimum patient care.

- Out of hours consultant cover on the coronary care unit (CCU) was through on-call arrangements only.

Evidence-based care and treatment

- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. For example we saw where best practice was followed in line with the National Institute for Health and Care Excellence (NICE) quality standard CG167: Myocardial infarction with ST-segment elevation: acute management. Myocardial Ischaemia National Audit Project data submitted by the trust audited services against NICE evidence-based standards.
- Staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). VTE is the formation of blood clots in the vein. We reviewed nine patient care records. All nine records demonstrated where patients had received a VTE risk assessment and had preventative VTE medication if indicated.
- A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. During our inspection we saw a number of care bundles in place. Examples included; sepsis, dementia care, peripheral and central lines and urinary catheters.
- There were pathways of care in place for patients admitted to respiratory medicine. For example, chronic obstructive pulmonary disease (COPD). COPD is the name used for a number of conditions including emphysema and chronic bronchitis, non-invasive ventilation (NIV), interstitial lung disease and lung cancer.
- There were integrated care pathways in place for all patients admitted to the angio-catheter suite. For example, the 'percutaneous coronary intervention' (PCI) pathway. This ensured patients received evidenced based care pre and post their procedure. PCI is a non-surgical procedure that uses a catheter (a thin flexible tube) to place a small structure called a stent to open up blood vessels in the heart.

- A 'delirium support tool' was used on ward 17 in accordance with NICE guidance CG103: Delirium: prevention, diagnosis and management. Delirium is most often caused by physical or mental illness, and is usually temporary and reversible.
- Patients on the coronary care unit could be monitored remotely using mobile cardiac telemetry (MCT). This meant patients could walk about whilst undergoing continuous cardiac monitoring.
- Local audit activity in the angio-catheter suite included an audit of the World Health Organisation (WHO) surgical safety checklist. Audit results for June 2016 demonstrated 96% compliance (against a target of 100%) with this checklist.
- Local audit activity included audits in; infection prevention and control, nursing metrics and observation and early warning scores (EWS).

Pain relief

- A 'pain aid tool' was available for patients who could not talk and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, body language and physical changes to help determine level of patient comfort.
- The Faculty of Pain Medicine's Core Standards for Pain Management (2015); Standards two and three were mostly implemented across the medical wards and relevant clinical areas. For example, nursing care records included care plans for pain. Pain was assessed and documented in all 12 patient observation charts we reviewed. However, during an unannounced visit to ward 16 a patient was visibly distressed due to pain, the patient's records did not show a regular review of their pain score since admission. We raised this with the nurse and the patient later informed us that their pain had been reassessed and their pain relief medicine dosage had been increased.
- During our unannounced visit we reviewed a further two patient records on ward 16. These patient records lacked regular pain scoring and assessment. Both records showed an initial pain score on admission which had not been re-assessed.
- Patient comfort during a colonoscopy procedure was measured using a five-point scale with zero equalling no discomfort through to five equalling very

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uncomfortable. Comfort scores for this trust between June 2015 and May 2016 showed across 3,728 procedures, 5.2% of patients indicated a comfort score of greater than four.

- Patients on the Clinical Decisions Unit (CDU) at the Glenfield Hospital told us their pain was well controlled and patients were well informed about their treatments.

Nutrition and hydration

- Fluid balance charts were used to record a patient's fluid intake and output and were important in monitoring a patient's fluid balance to prevent dehydration or over hydration for those patients who required a restricted fluid intake. On ward 15 we noted a patient where their fluid balance charts had not been sufficiently completed across a number of days. For example, only one entry on the chart for 14 June, no output recorded on the 21 June, no totals recorded on 15, 16, 17, 18, June and nothing recorded on the fluid balance chart on the 23 June to the time of our visit at 11am. We raised this immediately with the ward sister who assured us this would be addressed.
- During our unannounced visit to this hospital we reviewed seven patients requiring fluid balance charts across three ward areas. All seven fluid balance charts were up to date and accurately calculated.
- A nationally recognised screening tool was used throughout medicine to identify patients, who were malnourished or at risk of malnutrition. Staff used this tool to inform care planning and identify any specific dietary requirements. In all six nursing records the patient had been appropriately assessed using this tool.
- Staff had access to dietitian services Monday to Friday.
- Patients were provided with food and drinks whilst they were in the discharge lounge, soup and sandwiches as well as snacks cakes and biscuits were available. Drinks were being offered to patients during our visit to the area.
- On Ward 20 the meal ordering process was undertaken by facilities staff through the use of an electronic tablet. Each menu contained patient information to enable suitable choices of meals depending on an individual's dietary needs. Where a patient had moved from another ward the meal order would be transferred.

Patient outcomes

- The endoscopy unit was accredited by the joint advisory group (JAG). This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training.
- The trust participated in the Heart Failure Audit. Glenfield Hospital's results in the 2014 Heart Failure Audit were higher than the England and Wales average for five of the 11 standards. Glenfield Hospital's heart failure admissions numbered 669.
- The trust performed well in both the 2012/13 and 2013/14 Myocardial Ischaemia National Audit Project (MINAP) audits. MINAP is a national clinical audit of the management of heart attack. In 2013/14, almost 100% of patients who had sustained a non ST elevation myocardial infarction (NSTEMI), also known as a heart attack, were seen by a cardiologist or a member of their team, compared to 94% nationally and 83% were referred for, or had, an angiography, compared to 78% nationally. Angiography is a type of X-ray used to examine blood vessels. In total, 49% of patients experiencing a NSTEMI were admitted to a cardiac unit or ward compared to 56% nationally, this was the only standard to fall below the England national average.
- From January 2016 to May 2016 patients presenting with a NSTEMI waited on average four days to undergo a coronary angiogram, this was in line with NICE guidance CG94: Unstable angina and NSTEMI: early management, who recommend this should occur within 96 hours. A NSTEMI is a type of heart attack caused by a blood clot partly blocking one of the coronary arteries. A coronary angiogram allows the cardiac team to look inside coronary arteries for narrowing or blockage. Special dye is passed into the coronary arteries through a thin flexible tube (catheter) and shows up narrowed areas on an X-ray.
- The Glenfield hospital took part in the 2015 National Diabetes Inpatient Audit (NaDIA). Results showed the hospital had eight scores better than, and nine scores worse than, the England average. The indicator 'seen by the Multidisciplinary diabetic foot team (MDFT) within 24 hours' was significantly worse than the England average at 28.6% compared to 58% nationally. Results also demonstrated an increase in prescription errors between the 2013 (11.1%) and 2015 (32.8%) audits.
- Between August 2014 and July 2015 medical patients at this hospital had a lower than expected risk of readmission for non-elective admissions and a slightly

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higher than expected risk for elective admissions. The non-elective specialty, adult cystic fibrosis service, had the largest relative risk of readmission. Following our inspection we asked the trust for readmission rates for the reporting period August 2015 to May 2016. This was provided but was not broken down into the three hospital sites. Therefore, from August 2015 to May 2016 medical patients at this trust had a higher than expected risk of readmission for non-elective and elective admissions.

- Monthly reviews of feedback from carers of patients living with dementia, quarterly monitoring of dementia training figures and monthly monitoring of dementia screening were undertaken as part of the National Dementia CQUIN. The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this means better experience, involvement and outcomes. Data for the reporting period January to March 2016 showed 95.8% of patients were screened for dementia. This was better than the 90% target set by the commissioners of the service.
- If a patient develops an ST elevation myocardial infarction (heart attack), and requires treatment by primary percutaneous coronary intervention (PCI), then speed is of critical importance. The 'door to balloon time' is a measure of how long it takes a PCI centre to treat such patients. The audit standard for this should be less than 90 minutes. Data supplied by CCU for January 2016 to March 2016 showed this standard had been met in 90.5% of cases. The 'call to balloon time' is the measure of how long it takes a patient to undergo PCI from the time the patient calls for professional help. The audit standard for this should be less than 150 minutes. Data supplied by CCU for January to March 2016 showed this standard had been met in 86.4% of cases.

Competent staff

- Appraisal rates at the Glenfield hospital from April 2015 to March 2016 averaged 92% across all staff groups within medical services. This was better than previous years with appraisal rates at 86% for April 2014 to March 2015. We were not made aware of the trust's target for completion of appraisals.

- Quarterly monitoring of dementia training figures were undertaken as part of the National Dementia CQUIN. Dementia awareness training had been developed using a multi-agency approach and focussed on two categories; dementia category A (basic level, required by all employees) and dementia category B (enhanced level, required by staff working clinically with adult patients). Between January 2016 and March 2016 category A training had exceeded the trust target of 90% with 93% of staff having completed this training. For the same reporting period 89% of staff had completed category B training which was slightly lower than the trust target of 90%.
- The trust had employed a number of registered nurses from overseas. There was a comprehensive trust wide programme for overseas nurses which included an eight-week induction, followed by a minimum of four weeks supernumerary status within the clinical area. Ward sisters told us this could be extended if required.
- Ward 17H had a four-bedded high dependency unit (HDU). Staff working on this unit received enhanced training which included for example; non-invasive ventilation (NIV), early warning scoring (EWS), chest drain management, tracheostomy care and care of arterial lines. Information received following our inspection showed 18 out of 29 staff had completed HDU competencies for ward 17H. Senior staff in this area told us the off duty was arranged to ensure at least one member of staff who was HDU competent was on duty at all times.
- A comprehensive two-year competency based training programme was in place on the coronary care unit (CCU). Competencies included; intra-aortic balloon pump (an intra-aortic balloon pump is a mechanical device that helps the heart pump blood), continuous positive airway pressure, a treatment that uses mild air pressure to keep the airways open, high flow oxygen and advanced life support. We were not told how many staff on CCU had completed this training.
- Protected time was allocated to staffing rotas on CCU. This allowed for one, five-hour teaching session every two months for junior nursing staff.
- Percutaneous coronary intervention (PCI) competencies were mandatory in the angio-catheter suite. Senior nurses told us registered nurses would be expected to complete PCI competencies in addition to one years working experience in the unit before they could be available to work as part of the 'on-call' team.

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- Scrub assistants were not currently in place on the angio-catheter suite. Scrub assistants handle all instruments, supplies and equipment in the procedure room. Because they understand the current surgical procedure, they can anticipate the needs of surgeons and pass them the correct tools. Information received before our inspection from an external professional organisation had identified the lack of scrub assistants as an area of concern. A formal recommendation of the British Cardiology Interventional Society (BCIS) is that a scrubbed assistant should be present at all times to achieve optimum patient care. During our inspection staff within the angio-catheter suite told us they were currently training their first scrub assistant at a nearby NHS trust.
- Ionising Radiation (Medical Exposure) Regulations (IRMER) competencies were managed by the superintendent radiographer in the angio-catheter suite who maintained a central record for IRMER reporting purposes.
- On ward 28 an increasing number of patients requiring electrophysiology study (EPS) were being admitted to the ward. As a result, the ward sister told us they were in the process of scoping the need for advanced life support training for the registered staff in this area. Electrophysiology is a branch of cardiology that deals with the diagnosis and treatment of heart rhythm disorders.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering patient's care and treatment. We saw involvement from nurses, medical staff, allied health professionals (AHP) and specialist nurses. Most staff we spoke with told us that there were good lines of communication and working relationships between the different disciplines.
- Medical records demonstrated an MDT approach to the delivery of patient care. Throughout the care records we reviewed we saw input from for example; physiotherapists, consultants, dieticians, nurses, speech and language therapy (SALT) and specialist nurses.
- We saw where MDT meetings took place weekly as a minimum across all medical care wards and units. There was a MDT attendance at these meetings. For example, allied health professionals, nurses, medical staff and matrons of the service.
- On ward 17 a weekly 'huddle' took place with nursing staff. Discussions would include recent incidents, complaints and any ward concerns. For example, a recent huddle had included a discussion about a recent 'fall with harm' and subsequent duty of candour requirement.
- A monthly MDT took place in the angio-catheter suite; discussions included training and development and audit results.
- A mental health triage team were available at the trust. Between the hours of 8am and 10pm the team would see any patients on the wards who had been admitted as a result of self-harm. The response time for ward referrals was four hours. Overnight support to the wards was provided by the on-call duty psychiatrist. In addition to this service there was a liaison psychiatry service Monday-Friday 9am to 5pm. Outside of these hours any patients who required a review by liaison psychiatry were assessed by the on-call duty psychiatrist.

Seven-day services

- Twice weekly consultant-led ward rounds were reported to take place in respiratory medicine. With the remaining days covered by a specialist registrar. However, on the respiratory high dependency unit (ward 17H) consultant led ward rounds took place seven days a week.
- During our inspection concerns were raised regarding the irregularity of consultant led ward rounds in cardiology. There were two consultants on ward 28 with two rounds per week undertaken by one consultant and no regular ward rounds undertaken by the second consultant. 'Ad hoc' reviews of patients by the second consultant were reported to take place. Nursing staff felt this reduced the level of support available to junior medical staff. None of the junior medical staff raised concerns.
- Consultant cover on the coronary care unit (CCU) was provided, during the day, Monday to Sunday this included a consultant-led ward round. An interventional cardiologist is available 24/7 in supplement to this. Service leads told us two new consultant physicians had been created in Cardiology, to strengthen CDU Consultant Cardiologist input including weekends. Senior nursing staff told us both consultants would be able to attend the hospital within

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30 minutes. Service leads told us two new consultant positions had been created in cardiology to facilitate seven-day working on CCU. These positions were currently in the recruitment stage.

- Out of hours cover for the angio-catheter suite was provided by one consultant supported by a trained multi-disciplinary team in the Angio catheter suite.
- Weekend cover for CCU and the cardiology wards was provided by a specialist registrar (SpR). However, senior nursing staff were concerned if the SpR was called to the angio-catheter suite this would leave a junior doctor for the cardiology wards and CCU. They told us however, the critical care outreach team would be available for support. Senior staff were unsure if medical staffing had been raised on the risk register for medicine. We reviewed the risk register provided to us before our inspection, medical staffing cover for CCU and the cardiology wards had not been included.
- X-ray services were available at night with a portable machine on site.
- There was a consultant-led nurse supported system for managing acute gastrointestinal (GI) bleeds which was available 24 hours a day, seven days a week at this hospital. Trust wide there was an acute GI bleed 'on-call system'. Monday to Friday (9am – 5pm) a GI consultant triaged patients throughout the trust and arranged urgent endoscopy where required. Urgent endoscopies were booked onto an acute GI bleed list every afternoon, Monday to Friday at this hospital. Overnight there was an acute GI bleed consultant on-call who was available to endoscope patients who were acutely unwell. There was an on-call endoscopy nursing team who supported this activity. At weekends there was an on-call GI bleed consultant who had a dedicated list every Saturday and Sunday morning for emergencies and was available throughout the weekend for acute bleeds.
- Dietetics, physiotherapy and occupational therapy were available 9am to 5pm Monday to Friday. Where support was required from physiotherapy out of these hours an on-call system was in place.
- Speech and language therapy (SALT) were available 9am to 5pm, Monday to Friday. There was no weekend or bank holiday cover.
- Dedicated physiotherapy and occupational therapy staff were available in respiratory medicine. With physiotherapy provided 24 hours a day, seven days a week on ward 17H (high dependency unit).

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included risk assessments, care plans and case notes. Information and guidance regarding specific procedures or conditions was available through the trust intranet.
- The discharge lounge dialled into conference calls to determine the bed status and potential and actual discharges on the wards. Staff in the discharge lounge had direct access to the trust's electronic communication system and were able to see where in the discharge process each patient was at. For example, the GP letter and patients 'tablets to take home (TTO).
- Ward staff told us they had good access to a 'notes computer tracking system'. This located and retrieved medical notes for those patients previously admitted to the trust. Patients admitted to the wards through the clinical decision unit would have a new set of medical notes whilst their old notes from a previous admission would be requested.
- Access to specialist referrals for example, physiotherapy, occupational therapy and dietetics; diagnostic test requests and diagnostic test results were made through an electronic communication system, with most healthcare staff having access. Medical and nursing staff we spoke with described this as an efficient process.
- A 'discharge lounge checklist for the wards' was available for ward staff. This was filled in and signed by the ward staff and covered all aspects of the patients discharge. Key areas included the patients care package that had been put in place for discharge, and contact numbers of the provider services. This allowed the discharge lounge to contact home services if a discharge had been delayed or to confirm the time of actual discharge.
- Discharge summaries were sent to the patient's GP on discharge to ensure continuity of care within the community. Summaries were sent on the day of discharge electronically, by post or given to the patient for them to hand to their GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act (MCA) 2005 and consent. We saw consent to care

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and treatment was obtained in line with legislation and guidance, including the MCA and patients were supported to make decisions. Mental capacity means being able to make your own decisions.

- Where patients had the mental capacity to make a decision we saw consent to care and treatment was obtained and documented in the medical notes.
- Where patients lacked the mental capacity to make a decision, we observed, in the medical notes, where staff had made 'best interests' decisions in accordance with legislation.
- Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests. During our inspection we saw no patients receiving medical care who required a deprivation of liberty safeguard (DoLS).

Are medical care services caring?

Good



We rated the care provided to patients in medical care services as good because patients were supported, treated with dignity and respect, and were involved as partners in their care.

We found:

- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in their care and treatment.
- Staff positively interacted with patients and patients were treated with kindness, dignity, respect and compassion while they receive care and treatment. Feedback from patients was mostly positive about the care and treatment they had received.
- Patients were mostly involved and encouraged to be active partners in their care and in making any decisions.

Compassionate care

- We reviewed the NHS Friends and Family Test (FFT) results in Medicine for the period March 2015 to February 2016. The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Results showed the

average response rate to be 27%. This was better than the England average of 26% for the same reporting period. Results from this reporting period showed the coronary care unit consistently scoring well; between 96 and 100% of respondents would recommend the NHS service they had received to friends and family who may need similar treatment or care.

- FFT results for the clinical decisions unit at the Glenfield Hospital were 95% positive. We saw notices relating to the results in the department.
- Patients were treated with kindness, dignity, respect and compassion while they received care and treatment. All the staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- We spoke with 13 patients and two relatives during our inspection. Feedback from patients was mostly positive with nine patients commenting positively about every aspect of their hospital stay. Patients described the care they had received as "brilliant" and "staff were very friendly". Where negative feedback had been given to us this was largely due to delays in treatment, waiting times for discharge and infection prevention control issues. Feedback from two relatives was positive about every aspect of their relatives' stay.
- Privacy and dignity was considered a priority in the discharge process. As such, patients were encouraged to wear day/outdoor clothes in the discharge lounge.
- During our inspection staff on all the wards were polite and courteous to patients. We observed staff responding compassionately when patients needed help, and saw a number of examples of good care. For example, we observed staff introducing themselves to patients. Patients appeared comfortable and relaxed, the atmosphere on the wards was calm and call bells were silenced promptly.
- Wards included single-gender accommodation, which promoted privacy and dignity. Between February 2015 and January 2016 there was no reported episode when male and female patients had been treated in the same bay at this hospital.

Understanding and involvement of patients and those close to them

- During our inspection we spoke with 13 patients about whether they felt involved and understood about their care. Most patients told us they felt involved in their care and had an understanding of their treatment. However,

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one patient told us they thought they were going home but staff had not updated them. Another patient was concerned about the length of time it had taken to access a procedure in cardiology, with poor communication from the hospital.

- On the discharge lounge we observed a positive staff interaction with a staff member talking through a medicines information sheet with a patient. The member of staff engaged with the patient. They gave a clear explanation, discussing how long the patient should take the medicines for and any side effects the patient should look out for.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'University Hospitals of Leicester (UHL) carers charter' was developed in 2015. The carers charter described to carers what they could expect from staff in the trust. This included; identifying carers on the wards, assessing carers needs, ensuring open channels of communication and providing essential information. On Ward 17 we observed signs behind the patients bed alerting staff when a patient had a carer.
- On ward 28 a patient explained to us that staff had helped them to be able to place a vote in the European referendum whilst they were in hospital.
- We spoke with relatives in the clinical decisions unit at the Glenfield Hospital who told us they felt involved in the care of those close to them.

Emotional support

- Nursing care plans met National Institute for Health and Care Excellence (NICE) quality standard [QS15]: Patient experience in adult NHS services. Patients had their physical and psychological needs regularly assessed and addressed, with care plans including an assessment of nutrition, hydration, pain relief, personal hygiene, rest and sleep, psychological and emotional well-being and promoting health and safe care.
- Clinical nurse specialists were available for advice and support in a number of specialties including cardiology and respiratory medicine.
- Nursing and medical staff were available to offer emotional support and reassurance to patients and relatives. For example, on the coronary care unit (CCU) relatives, where a request had been made, were

supported to witness the resuscitation procedure carried out on their loved one. Staff told us this sometimes helped reassure relatives that everything had been done to 'save' the patient.

- A specialist bereavement nurse was available to offer support to bereaved relatives. For example on CCU the specialist bereavement nurse would ring relatives following a patients cardiac arrest.
- Patients and relatives on CCU were offered an opportunity to return to the unit at a later date. Nursing staff told us this often helped patients and relatives to 'come to terms with' their experience on the unit.

Are medical care services responsive?

Good



We rated the responsiveness of medical care services as good because patient's needs were met through the way services were organised and delivered.

We found:

- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.
- It was easy for patients to complain or raise a concern. Posters and leaflets were available in the wards and clinical areas these allowed members of the public to identify how they could raise a concern or make a formal complaint.
- There was a proactive approach to understanding and meeting the needs of individual patients and their families and services were planned and delivered to meet the needs of local people with direct access to specialist cardiology services.
- Response times for ST elevation myocardial infarction (heart attack) were similar to national targets.

However we also found;

- The referral to treatment times (RTT) for the cancer standards were not being achieved by the trust. Between April 2014 and December 2015 cancer waiting time standards for the two week wait standard, the 31 day standard and the 62 day standard had not been achieved and was worse than the England average for every month.

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- Access to diagnostic tests within six weeks of referral was worse than the England average; since June 2015 the trust had performed worse than the England average, with a higher than average percentage of patients waiting six or more weeks for diagnostics.

Service planning and delivery to meet the needs of local people

- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital. For example, an ambulatory heart failure clinic was available Monday afternoons and Tuesday and Wednesday mornings; a rapid access atrial fibrillation clinic was available seven days a week and; a rapid access chest pain clinic was available Monday to Friday during normal working hours.
- Advanced interventional work in cardiology included an increase in transcatheter aortic valve implantation (TAVI). TAVI is the replacement of the aortic valve of the heart through the blood vessels (as opposed to valve replacement by open heart surgery). This was usually performed under general anaesthetic. However, for those patients with multiple risk factors the service had introduced this procedure under local anaesthetic.
- Information about the needs of the local population was used to inform how services on the coronary care unit (CCU) were planned and delivered. For example, commissioners involved in planning services had agreed that CCU should be exempt from single-gender accommodation regardless of the acuity level of the patients.
- Within the clinical decisions unit at the Glenfield Hospital a pneumonia nurse specialist provided support for staff caring for patients admitted with pneumonia. The nurse also followed up patients in the community and ensured follow up diagnostic tests were arranged.
- The coronary care unit (CCU) received direct admissions through a local NHS ambulance trust; this included those patients experiencing an 'out of hospital' cardiac arrest. Where there was uncertainty regarding the patients need for a bed on CCU paramedics would utilise an electrocardiogram (ECG) application through a 'hand held' tablet device. This allowed paramedics to check a patient's heart rhythm and electrical activity and forward it electronically to the CCU for advice and support before admission.
- There was a clear admission process to the discharge lounge to ensure the safety and suitability of patients who were discharged through the discharge lounge. Patients living with dementia or who had pressure ulcers were not admitted to the discharge lounge. Staff monitored and actively managed the patients discharge process to facilitate a safe and prompt discharge. Examples of delays in the discharge process for this area included waiting for 'tablets to take home' (TTOs) as a result; a pharmacy technician was now part of the discharge lounge team. Nursing staff within the discharge lounge told us current delays were usually caused by ambulance transport delays. On these occasions the duty manager would be informed and patients would have to wait on other wards if the discharge lounge was due to close. This would not necessarily be the ward where they had previously been cared for.
- On average elective and non-elective patients spent less time in medical care services than the national average. The average length of stay for elective patients at Glenfield hospital from March 2015 to February 2016 was 2.2 days, compared to 3.9 days for England. For non-elective patients, the average length of stay was 4.6 days, compared to 6.7 days for England.
- The length of stay for patients attending the angio-catheter suite for all procedures was on average 10 days. The trust carried out a sample audit of 50 records from 18 April 2016 to 21 April 2016 which demonstrated on average a five day wait from referral to procedure. As a result of an increased wait for procedures the angio-catheter suite were part of the trust 'better change project charter' and had created a multidisciplinary team (MDT) project to drive quality, reduce length of stay and improve flow within the

Access and flow

- Admissions to the angio-catheter suite were through the emergency department, the clinical decision unit, the coronary care unit and other wards throughout the trust. There were also direct admissions through a local NHS ambulance trust.
- Staff within the angio-catheter suite were alerted to the imminent admission of a patient requiring percutaneous coronary intervention (PCI) through the use of a bleep system.

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angio-catheter suite. We reviewed the project charter and could see that there were clear objectives along with key benefits and mile stones set. The project team met weekly to discuss progress.

- The respiratory early discharge scheme (REDS) was in place to speed up hospital discharge for patients with respiratory conditions, especially those with chronic obstructive pulmonary disease (COPD). COPD is the overall term used to describe a variety of illnesses, including chronic bronchitis, emphysema and chronic obstructive airways disease. Patients receiving care under the scheme remained the responsibility of the hospital consultants until they were discharged from the scheme. Respiratory nurses helped patients adjust back at home. Visits were made to patients in hospital and also at home for up to a week. The REDs team provided help for newly diagnosed patients new to having oxygen or nebulisers and follow-up care for patients who were regularly readmitted to hospital to find out why and to help them feel safe and secure at home. The specialist nurse team planned to review and assess all COPD patients who were currently experiencing an exacerbation, and implement a range of interventions under a COPD care bundle, this includes education review of inhaler techniques, referral to community COPD service, pulmonary rehabilitation and post discharge follow up phone calls.
- Following our inspection we asked the trust if they monitored delayed transfers of care in medicine. Data provided for December 2015 to May 2016 demonstrated there were 1,036 delayed transfers of care bed days reported. Reasons for delayed transfers of care, and medical specialty were not provided.
- The average bed occupancy in medicine for the reporting period April 2015 to March 2016 was 91.6%. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- Between April 2014 and December 2015 cancer waiting time standards for the two week wait standard, the 31 day standard and the 62 day standard had not been achieved and was worse than the England average for every month. Cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England.

- For the reporting period March 2015 to February 2016, 64% of patients' did not move wards during their admission, and 36% moved once or more.
- Data for the reporting period October 2015 to March 2016, showed across 12 clinical areas 362 patient transfers had occurred after 10pm with 36% of transfers from the coronary care unit.

Meeting people's individual needs

- There was a system in place for identifying patients in the hospital who had diabetes. An automated daily report that included patient level detail and location of their inpatient stay was sent to key members of the diabetes team.
- A diabetes specialist nurse (DSN) service was available at this hospital for the care of inpatients with diabetes. The service was supported by a specialist registrar (SpR) who was on call for the speciality. The team were contacted through an electronic referral system and/or bleep. The DSNs were proactive in attending the acute assessment areas every day to identify new admissions to the hospital. There was an 'inpatient diabetes safety committee' which included a lead consultant, lead specialist nurse and consultant nurse.
- Staff had access to an external interpreting service 24 hours a day, seven days a week. The service included the provision of British sign language (BSL). There was an interpreting and translation policy in the trust.
- In the discharge lounge the pharmacy technician ensured as many patients as possible were discharged with a 'medicine information card'. This was an A4 printed sheet with a clear list of their medicines including dose and frequency. Information was provided in large font to assist in the safe self-administration of medicines after discharge.
- There were 2.5 whole time equivalent (wte) acute liaison nurses (ALN) that provided advice and support to patients admitted to the trust who had a learning disability. In addition to this a flagging system linked to the Leicestershire learning disability register alerted the team, through the trust patient administration system, of any patient admission who had a learning disability.
- We observed a patient at in the Clinical Decisions Unit (CDU) at the Glenfield hospital who had a learning disability. We saw there had been input from the learning disabilities nurse and specialist one to one care had been arranged to support the patient overnight.

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- Patients living with a learning disability were assessed using standardised nursing and medical documentation. Where patients had their own hospital profiles they were asked to bring them into hospital with them. On receipt of notification of an admission the ALN would contact the ward and telephone assess the level of priority in terms of their visit i.e. patients with more complex needs may be seen more quickly. However all inpatients were to be seen or the ward contacted within 24 hours of admission. On attendance the ALN would assess what reasonable adjustments were required in addition to speaking to carers about the care needs of the patient.
- Between February 2016 to June 2016, trust wide, 230 patients recorded as having a learning disability were admitted into hospital. Of these, 19 were not seen by the ALN because the patient came in either as a day patient or over the weekend/bank holiday. The ALN service operates Monday to Friday, 8am to 5pm. Of the 211 patients seen 190 had a confirmed learning disability. Of the 190 patients seen 54% were seen by a member of the ALN team within 24 hours of admission. The reasons for not being seen within 24 hours were; the admission was at the weekend or bank holiday; the patient had not been identified to the ALN at the point of admission and the patient was admitted and discharged out of hours.
- In 2015 'Patient-Led Assessments of the Care Environment' (PLACE) were extended to include criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia. The assessment, of the premises for people with dementia, demonstrated a compliance level of 72.8% which was slightly worse than the England average of 74.5%.
- The trust was committed to the implementation and delivery of service improvements for people with dementia in Leicester's hospitals. Person centred care was individualised to meet the specific needs of each patient using the 'know me better' patient profile. The patient profile form allowed the patient to provide information to the health care team that detailed their psychosocial needs, concerns, and what was important to them during their hospital admission. The form was completed by the patient, with or without the assistance of their family. Open visiting was available to carers of patient's living with dementia. A bespoke 'meaningful activity service' had been created and included reminiscence tea parties to encourage patients with nutrition and hydration. There was ongoing work to upgrade the environments to make them dementia friendly with the availability of quiet rooms and retreat rooms. Policies were in place to reduce the number of ward transfers for patients with dementia.
- Patients and carers were signposted and had access to charitable organisations for additional support and information. Whilst in the trust, a dementia 'champion network' of staff with a particular interest in dementia supported patients.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Clinical and cognitive assessments were undertaken as part of the dementia care pathway. Care pathways are multidisciplinary plans of anticipated care.
- Trust funds had been made available on the discharge lounge for the purchase of new clothes for patients who were unable to provide their own for whatever circumstance. They were also made available for ward patients who were without suitable discharge clothing.
- Pastoral, spiritual and religious support was available to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Islamic and Sikh chaplains, as well as the country's first paid non-religious carer who, focussed on meeting the needs of patients who did not identify with a religious belief. The team was also supported by volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives. A 24/7 on-call service was provided and where possible a representative of the patient's own faith would attend. The service was widely publicised through posters, leaflets and the trust website.
- A chapel and prayer room (with washing facilities) was available at this hospital and was designed to meet the diverse religious and spiritual needs of patients and staff. Rooms provided a quiet place for private prayer, meditation and contemplation and were open to everyone.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the trust's equality advisory group. This group advised on various faith issues including modesty and patient food.

Learning from complaints and concerns

- Posters and leaflets were available in the wards and clinical areas we visited. These allowed members of the

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public to identify how they could raise a concern or make a formal complaint. We also saw 'message to matron' cards and boxes to allow patients and relatives to make comments or raise concerns which where possible could be dealt with locally.

- A patient information and liaison Service (PILS) was available at the trust for members of the public to raise a query or concern, access information or to make a formal complaint about the services provided to them.
- Between March 2015 and March 2016 a total of 51 complaints were received in medical care services at this hospital. The top three themes for complaints within this service were; medical care (16), communication (nine) and nursing care (five). For the same reporting timeframe, eight complaints had been received in relation to the clinical decisions unit at the Glenfield hospital.
- Senior nurses and ward sisters were aware of concerns and complaints raised within their areas. Information around concerns and complaints were discussed at team meetings, handovers and during morning 'board huddles'. Nursing staff told us of changes that had been made as a result of concerns or complaints. Examples included, the introduction of pressure ulcer assessments in the discharge lounge, a member of staff taking responsibility for ensuring tablets to take home (TTO) information was given to patients and records in use to confirm where patients have received care.

Are medical care services well-led?

Good



The leadership of medical care service at this hospital as good.

We found:

- There was a vision and strategy for this service and whilst it was very strategic staff were able to describe this to us during our inspection.
 - Staff were consistent in delivering care and demonstrating behaviours in line with the trust vision and values.
 - Staff satisfaction was mostly positive with staff reporting good support at a local level. Staff were engaged and empowered to raise concerns where necessary.
 - Staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support
- However, we also found:
- Departmental governance and risk management arrangements were not effective and as such able to protect patients from avoidable harm. The process for identifying deteriorating patients was not robust and where patients had met the trust criteria for sepsis screening, not all patients were screened appropriately; this put patients at risk of not receiving the correct treatment in a timely manner.
 - Scrub assistants were not currently in place on the angio-catheter suite. Scrub assistants handle all instruments, supplies and equipment in the procedure room. A formal recommendation of the British Cardiology Interventional Society (BCIS) is that a scrubbed assistant should be present at all times to achieve optimum patient care.

Vision and strategy for this service

- Medical care (including older people's care) was provided at this hospital as part of three clinical management groups (CMGs): Cancer, haematology, urology, gastroenterology and surgery (CHUGGS), and renal, respiratory and cardiovascular.
- Most staff we spoke with were able to articulate the trust's vision and the values, which was to deliver 'Caring at its best' for everyone who visited the trust. Underpinning this was the trust values which were ; 'We treat people how we would like to be treated'; 'We do what we say we are going to do'; 'We focus on what matters most'; 'We are one team and we are best when we work together' and; 'We are passionate and creative in our work'.
- University Hospitals of Leicester NHS Trust had a detailed five year integrated business plan which covered 2014 to 2019. A two-year 'operational plan' was in place within emergency and specialist medicine with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy. Some staff were aware of the details included within this operational plan and told us of the movement of specialist services to one of the other hospital sites within the trust and plans to increase capacity within medicine.

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- Operational plans were also in place within the renal, respiratory and cardiovascular clinical management group and CHUGGS clinical management group.

Governance, risk management and quality measurement

- A comprehensive risk register was held within medicine with 32 risks identified. Risks included a description, controls in place to mitigate the risk and a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register. Service leads cited negative feedback from junior doctors in cardiology as a challenge as there was one middle grade doctor on duty who could be required to undertake cardiology procedures. This left the hospital without any middle grade availability to other patients.. To mitigate the risks an education action plan had been put in place to maximise training opportunities and offer more support at ward level. However, service leads did not mention the concerns we had identified regarding the process for identifying the deteriorating patients, and this was not included on the risk register.
- The lack of scrub assistants in the angio-catheter suite had been raised as a significant concern prior to our inspection. However, this had not been identified on the CMG risk register.
- Senior leads had a good knowledge of complaints themes within the service with their top three complaints aligned to our review of complaints.
- Staff received regular updates through email, on staff notice boards, during morning board rounds and at ward and department meetings. Updates included information such as incident and complaint themes, serious incidents, any safety thermometer information at ward level, medical device information and any relevant trust wide information. Staff we spoke with demonstrated a good awareness of incidents that had occurred within medicine in addition to changes that had been made as a result of incidents across other CMGs.
- Nursing staff reported good local escalation plans for governance arrangements within this hospital. Examples included, monthly sisters meetings at Glenfield Hospital, monthly ward meetings, matron involvement in monthly mortality and morbidity meetings and involvement in review meetings for falls and hospital acquired pressure ulcers

- Within cardiology a monthly 'in-depth' review meeting took place. Content of this meeting included a review of all incidents, audit performance and patient experience. On CCU a review of the Myocardial Ischaemia National Audit Project (MINAP) audit data and 'out of hospital cardiac arrests' took place quarterly and included input from external National Health Service (NHS) providers.

Leadership of service

- Leadership of the acute medicine / emergency department and renal, respiratory, cardiovascular clinical management group (CMG) was provided by a Head of Nursing, a Clinical Director and a Head of Operations, and renal, respiratory and cardiovascular was provided by a head of service and a general manager.
- Locally, staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support.
- Without exception staff we spoke with were consistently positive about local ward leadership across all areas in medical care services at this hospital. Staff told us ward leaders were "passionate", "very visible", and had an "open door" policy.
- Ward leaders and matrons spoke of ward staff with pride. We observed an obvious mutual respect amongst staff, ward leaders and matrons.
- Junior doctors mostly reported good support from senior doctors and consultants .
- All staff, both medical and nursing, were aware of the trust whistleblowing policy. Staff told us they felt listened to and felt empowered to raise concerns.
- Staff in the clinical decisions unit felt very well supported by their seniors and in particular the head of nursing for the clinical decisions unit.

Culture within the service

- Staff felt respected and valued, happy to work at the trust and felt part of their immediate team. We observed staff working as a team on all of the areas we visited and saw high levels of patient engagement.
- On all of the areas we visited staff spoke of patients being the focus of their work. We saw staff consistently delivering care and demonstrating behaviours in line with the trust vision and values.
- Duty of candour briefing sessions had been held in medicine for all levels and staff groups. Roadshows were

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undertaken at each hospital site to raise awareness of duty of candour. A duty of candour slide had been added to the complaints e-learning module that all staff were able to access through the electronic trust training portal. A duty of candour slide was also included on the trust induction programme for all new starters and on the medical directors induction slides for new trainee doctors to the trust.

Public engagement

- The NHS Inpatient survey looked at the experiences of 83,116 patients who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust. Responses were received from 547 patients at this trust. With the exception of 'cleanliness of rooms or wards' the trust received a rating of 'about the same' on how performance compared with most other trusts. Cleanliness of rooms or wards received a rating 'worse than' most other trusts.
- 'Message to matron' cards and boxes and, 'you said, we did' posters were visible in all ward and clinical areas to encourage the public to comment on services provided. Changes as a result of feedback / public involvement included a refurbishment on ward 28.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the trust's equality advisory group. This group advised on various faith issues including modesty and patient food.
- In the clinical decisions unit at the Glenfield Hospital we saw notice boards displaying 'you said, we did'. This demonstrated actions the unit had taken in response to patient feedback. Comments related to long delays from patients' initial journey to the end of their stay. We saw actions had been put in place to ensure the patients' journey was kept to a minimum.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.

- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.

Staff engagement

- We spoke with 27 staff from a variety of roles. Most staff were engaged and felt able to raise concerns and felt empowered to suggest new ways of working within their areas. All staff were invited to attend a monthly chief executive officer (CEO) briefing. Staff told us this was an effective way to learn about current issues within the trust.
- Staff were engaged and felt empowered to suggest new ways of working within medical care services. For example, staff on ward 17 had developed a transfer form to be used when transferring patients out of the high dependency unit (HDU). However, on the discharge lounge a proposal, made by a member of staff, to allow some patient's living with dementia to be discharged from this area had been initially rejected by the trust. The member of staff had explained that the staff to patient ratio and level of observation was usually higher than on most ward areas.
- On the discharge lounge a morning huddle was taking place when we arrived, staff were being updated about the day's work and about our visit and what to expect. The ward sister was observed to be very supportive. Staff told us they were kept up to date and felt supported in their role.
- On ward 20 a communication book was in use, emails were sent to staff and there were 'staff huddles'.
- Within the clinical decisions unit there was a positive culture in which staff felt proud and valued. They told us how much they enjoyed their work.

Innovation, improvement and sustainability

- A range of ambulatory clinics were available across the three CMGs to provide outpatient assessment within 48 hours for patients presenting with urgent conditions that did not necessitate immediate action.
- The cardiology department was recognised as being amongst the leading centres in the United Kingdom (UK). It provided a 24-hour primary angioplasty (surgical repair or unblocking of a blood vessel, especially a coronary artery) service. It was the first unit in the UK to

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perform a percutaneous aortic valve replacement procedure. The electrophysiology unit had a well-developed radiofrequency ablation service and was pioneering the use of robotic technology.

- A proactive approach to recruitment was observed in the angio-catheter suite with an 'open day' to promote opportunities for newly qualified staff and rotational posts with ward 32.

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Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

University Hospitals of Leicester NHS trust provide a range of surgery and associated services at the Glenfield Hospital (GH) as part of four clinical management groups (CMG's). These are; cancer, haematology, urology, gastroenterology and general surgery (CHUGGS), critical care, theatres, anaesthesia, pain and sleep (ITAPS), musculoskeletal and specialist surgery (MSS) and renal, respiratory and cardiovascular (RRCV).

At this hospital, there are 74 inpatient beds across four surgical ward areas and 5 day case beds. Inpatient services include some general surgical specialties; upper gastrointestinal, colorectal and urology. However, mainly specialise in cardiac, thoracic and breast surgery. Services for surgical patients are provided in outpatient consultation sessions, the pre-operative assessment areas, and inpatient wards.

The surgical division had eight theatres, two of which were laminar flow (this is a type of air conditioning that reduces air borne infections). There is provision for emergency surgery into any of the theatres Monday to Friday. Out of hours and at weekends and bank holidays three theatres remain set up with an on-call team available within 30 minutes of the hospital.

Between April 2015 and March 2016, there were 4,353 episodes of care. Of these, 5% were non-elective (emergency) admissions, 45% were day case procedures, and the remaining 50% were elective (planned admissions). Breast was the specialty with the largest percentage of episodes of care with 31%.

During our inspection, we visited the operating theatres, recovery and four surgical wards.

Before the inspection, we reviewed performance information from and about the trust. During our inspection, we spoke with 10 patients and two visiting relatives. We spoke with 18 staff members from a range of surgical related roles including doctors, nurses, physiotherapists, occupational therapists, health care assistants, trainee doctors and senior managers. We received comments from people who contacted us to tell us about their experiences. We reviewed treatment and care records for 12 patients and observed staff interactions with patients during the course of their activities. We also reviewed the arrangements in place to support the delivery of elective and emergency surgery, including the environment and provision of resources.

Surgery

Summary of findings

We rated surgical care services as good overall.

Safety of medical services was rated as requires improvement.

- Patients were not always protected from avoidable harm. Control of Substances Hazardous to Health (COSHH) was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. Cleaning fluids were not always stored in locked cabinets.
- Systems and processes are not always reliable or appropriate to keep people safe. Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments completed in a timely manner or reviewed after 24 hours.
- Monitoring and audit of safety systems was not robust. There was no effective audit for the World Health Organisation (WHO) five steps to safer surgery checklists.
- Potential risks to surgical care services were anticipated and planned for with all staff demonstrating an awareness of the arrangements in place to respond to emergencies and major incidents.
- There were systems, processes and standard operating procedures in infection prevention control, records, and maintenance of equipment, which were mostly reliable and appropriate to keep patients safe.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse.

We judged that surgical care services in effective, caring, responsive and well led were good.

- Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation and patients received effective care and treatment.
- We saw where patient's symptoms of pain were mostly managed in both ward and department areas with good comfort outcomes. Staff were proactive in assessing the patient's nutrition and hydration needs.

- We observed staff positively interacting with patients and patients were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was positive about the care and treatment they had received.
- Surgical care services were responsive to patient's needs; patients could access services in a way and at a time that suited them and there was a proactive approach to understanding and meeting the needs of individual patients and their families.
- The leadership, governance and culture in surgical care services supported the delivery of high quality person-centred care; departmental governance and risk management arrangements were mostly effective and as such able to protect patients from avoidable harm.

Surgery

Are surgery services safe?

Requires improvement



We rated safety of surgical services as requires improvement because there was limited assurance about safety.

We found;

- Systems and processes were not always reliable or appropriate to keep people safe. Patients preparing for surgery did not always have venous thromboembolism (VTE) assessments reviewed after 24 hours.
- Mortality and morbidity reviews were not used to influence service improvements. Clinical management groups (CMGs) did not always share learning across CMGs from mortality and morbidity meetings.
- Monitoring and audit of safety systems were not robust. There was no effective audit for the World Health Organisation (WHO) five steps to safer surgery checklists.
- Monitoring of safety systems relating to safe storage of medicines was not robust. Correct recording and monitoring of medicine refrigerator temperatures did not take place. There was no staff consistency in understanding the correct checking method. Action was taken at the time of the visit to address deficiencies in monitoring.
- Patients were not always protected from avoidable harm. Control of Substances Hazardous to Health (COSHH) was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids were not always stored in locked cabinets.

However we also found;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses, and could demonstrate where changes to practice had been made as a result.
- Patients were protected from abuse; staff had an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns.

- Systems, processes and standard operating procedures in infection prevention control, records, and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- Nursing and medical staff were up to date in mandatory training and levels of staffing and skill mix of nursing staff were managed appropriately with the use of bank and agency. An effective induction process was in place for locum, agency and bank staff. This ensured patient's safety.

Incidents

- An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff.
- Incidents were reported through the trust's electronic reporting system. All the staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. For example, a patient suffered a skin sensitivity reaction to an item of hospital clothing. This was reported, and information shared including lessons learnt. The patients' medical notes were also updated to ensure during any future hospital visits the same incident did not occur again.
- All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- There were no never events at Glenfield hospital (GH) between May 2015 and December 2016 within surgery. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a never event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Glenfield Hospital reported two serious incidents in surgery services between May 2015 and April 2016. One surgical/invasive procedure and one operation/treatment given without valid consent. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

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- The two serious incidents were both subject to root cause analysis (RCA). An RCA is a method of problem solving used for identifying the causes of faults or problems. We looked at the reports and found them to be thorough and included the relevant staff as part of the investigations. Actions were identified, for example in the case relating to consent audits were recommended to review how robust training was in relation to consent and the World Health Organisation (WHO) five steps to safer surgery checklist. However, this has not yet taken place.
- Two nurses and a ward sister told us about a serious incident within the trust and the action that was identified as a result. Documented hourly checks of all patients in side rooms had been introduced. We saw documentation outside of all occupied side rooms confirming these checks at GH.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff on all wards could describe an incident where duty of candour applied. For example, we witnessed a patient deferred for a cardiac operation as a result of an emergency patient needing immediate surgery. The deferred patient was taken to intensive care and both the surgeon and the anaesthetist apologised for what had happened.
- Duty of candour briefing sessions were held in all clinical management groups (CMGs) for all staff groups. Roadshows had been undertaken at each hospital site to raise awareness of duty of candour. A slide was added to the complaints e-learning module that all staff were able to access via the Electronic University Hospital Leicester (E-UHL) training portal. This was also included in the UHL induction programme for new starters to the trust.
- The serious incidents were both subject to duty of candour regulations. Both patients were informed of the respective incidents and were to be invited to a meeting with the surgical teams to discuss the action plan and receive a formal apology.
- Between March 2015 and March 2016 there were 248 incidents reported in surgical areas at GH. Low or no harm incidents accounted for 98% of the incidents. There was one moderate incident and 14 incidents reported as a near miss. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so. There were no incidents that were graded as 'major' and none that resulted in severe harm or death. Themes of the incidents included falls, pressure ulcers and medication incidents.
- Ward and theatre staff gave specific examples of learning from incidents and all staff told us they received feedback after reporting an incident. Ward sisters and managers said they provided feedback via email and newsletters. The electronic reporting system had a section for staff to request feedback.
- The ward sister on the thoracic surgery ward F26 introduced a daily 'sisters huddle' to discuss current incident themes. This meant staff were informed of current concerns.
- Staff within the different surgical CMGs held bimonthly morbidity and mortality meetings. These meetings reviewed patient deaths and treatment complications in order to develop improvements to patient safety and aid professional learning. Minutes from these meetings demonstrated all unexpected deaths were reviewed and trends identified. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Learning was shared through the clinical audit leads forum which met 4 times a year, individual cases were shared through LEG, RCA reports were circulated to all CMGs.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and harm free care. Data was collected on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers (PU), falls, urinary tract infections in patients with a catheter (CAUTI), and blood clots or venous thromboembolism (VTE).
- Information provided by the trust showed between September 2015 and March 2016, wards F24 (breast surgery) and F26 (thoracic surgery) provided 100% 'harm free care' and ward F31 (cardiac surgery) provided 95-100% harm free care, reporting one catheter associated urinary tract infection (CAUTI) and one pressure ulcer (PU).
- Safety thermometer data was not publicly displayed on any of the wards or clinical areas we visited. This meant patients and the public could not see how the ward was

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performing in relation to patient safety. Nursing staff told us it had been a trust decision not to display this data. Wards were told the emphasis was on the 'you said we did' boards. These boards are used to identify something a patient or relative has given feedback about and how the trust has responded to it. However, use of these boards was not consistent on all wards.

- Ward sisters and senior nurses on the wards and in theatres told us that matrons collected and reviewed all scores each month.
- Ward sisters and service leads attended a monthly forum and peer review meeting to discuss performance and plan actions for their areas in relation to safety thermometer results.
- Ward staff told us this was then cascaded to them at ward meetings or at the daily safety huddles. (Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical and opportunities understand what is going on with each patient and anticipate future risks to improve patient safety and care).
- On ward F31 we saw this information was fed back to the ward team and if there were any concerns identified they would become the 'focus of the month' For example; reducing incidents of pressure ulcers by ensuring accurate completion of relevant documentation. The whole team were involved in deciding the focus; this ensured individual engagement leading to a positive outcome. Once a focus had become accepted practice, another one would be reviewed.
- The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 3, statement 1 stated all patients, on admission, should receive an assessment of VTE and bleeding risk. The trust's performance report for March 2016 showed 96% of VTE assessments were completed on admission. Within surgery, completion was 95% and met the trust's target of 95%.
- Ward and theatre staff told us that if VTE assessments had not been completed before surgery anti embolic stockings (AES) were not applied. These stockings are designed to increase the blood flow in the leg veins by compression. Staff reported that in these instances AES were sent with the patient to theatre to be applied in the anaesthetic room. Staff told us that occasionally

patients had not had the prescription written prior to theatre. We reviewed 12 patient care records. All 12 demonstrated where patients had received an initial venous thromboembolism (VTE) risk assessment.

- The NICE QS3 statement 4 stated that patients should be reassessed within 24 hours of admission for the risk of VTE and bleeding. We reviewed 12 patient records and found that these VTE reassessments were not done in six of them. This meant some patients were receiving anticoagulant (blood thinning) therapy for longer than necessary and could increase the risk of harm to patients.

Cleanliness, infection control and hygiene

- Glenfield Hospital (GH) participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this hospital demonstrated a compliance level of 97%, which was almost equal to the England average of 98%.
- Trust wide there had been 67 cases of clostridium difficile (c. difficile) infections between March 2015 and April 2016 with one case occurring at this hospital in the surgical areas. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Meticillin resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between April 2015 and April 2016, there were 15 cases of MRSA with none in the surgical areas at GH.
- Patients were screened pre-operatively for MRSA and as soon as possible when admitted as an emergency. This was in line with local policy and national guidance.
- All cardiology and surgical (cardiac and thoracic) were MRSA screened wards. On the elective wards patients were screened in preadmission. In the non elective wards patients were screened for MRSA on admission to the ward. This meant all patients were tested for MRSA as part of the admission process. Any patient found to be a carrier of MRSA would be treated appropriately. This ensured that all patients requiring surgery at GH were protected from unnecessary harm. Any outlying

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patients that had not been screened were isolated and treated for MRSA until swabs proved negative. We saw evidence of negative MRSA screen results in all 12 patient records we reviewed.

- Four nurses and ward F24 explained that a bay at the end of the ward would be used for unscreened or outlying medical patients. The bay had its own toilet and shower facilities this meant surgical patients were at reduced risk of harm.
- The trust had reported one surgical site infection for the year 2015. A full investigation was carried out which concluded a cause could not be identified. Surgical site infection surveillance (SSIS) is mandatory for all trusts although not all categories of surgery are required to be included. The trust reported on surgical site infections for hip and knee replacement surgery at the Leicester Royal Infirmary site.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy. Following our inspection, we asked the trust for any actions taken as a result of these audits. The trust response was there was no evidence of actions taken in result of audits.
- However all four wards at GH had infection control link nurses. We were shown evidence of extra training they had delivered if hand hygiene results were worse than the trust target of 90%.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. Results for December 2015 for two elements of the audit; before patient contact and, after patient contact demonstrated 51% and 63% compliance respectively across the trust. (Not specifically broken down for Surgery) This was better than the trust's overall compliance figures but worse than the trust target of 90%.
- There was access to hand washing and drying facilities on wards and a good supply of personal protective equipment (PPE), which included gloves and aprons.

These items were used by staff and disposed of correctly afterwards. We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw staff followed best practice guidance when giving intravenous fluids and taking blood samples.

- We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw staff followed best practice for hand washing and remaining bare below the elbow to allow for effective hand washing.
- We saw patients with infections nursed in side rooms and appropriate signage was in place to alert staff and visitors of action they needed to take. Personal protective equipment was provided for staff. Visitors were advised about hand washing and wearing gloves and aprons as required. We witnessed staff on ward F26 appropriately caring for one patient in a side rooms according to hospital policy.
- We observed staff following National Institute of Health and Care Excellence (NICE) Clinical guidelines [CG74]2008 surgical site infections prevention and treatment within theatres. For example, there was alcohol foam on entry to anaesthetic rooms. Theatre staff were observed to adhere to best practice principles for 'scrubbing up', (rigorous hand and arm washing), prior to surgery and for the management of surgical equipment in the operating environment including the use of separate clean and dirty decontamination areas in cardiac theatres at GH.
- On the surgical ward areas, pre-assessment rooms, operating theatres and recovery, we found the standard of cleanliness was visibly good. The trust produced a bed space-cleaning checklist, which was filed in patient notes as evidence of a pre admission clean. We saw this chart completed during our inspection at GH.
- We saw equipment-cleaning schedules on all wards. We also saw good use of 'I am Clean' stickers in ward areas to indicate where staff had signed to say equipment had been cleaned and was ready for patient use. All 14 pieces of equipment we saw were visibly clean and ready for use.
- Throughout the hospital, privacy curtains were a mixture of disposable and non-disposable. Nursing and housekeeping staff told us they were unsure what the exact schedule was for changing them but that they were changed if visibly soiled or following patient isolation. The disposable curtains had dates on them

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indicating when they were put up but staff suggested various time spans for routine changes between two and four months. This is contrary to Health Building Note 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.

- The local policy provided by the trust after our inspection, identified curtains in in-patient areas should be changed every six months. However, not all staff we spoke with were able to identify this. We were therefore not assured it was being completed as per local policy.
- The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow. This separation ensures clinical waste legislation is adhered to and waste is stored, transported and disposed on in the correct manner. Ward and theatre staff reported no training in relation to waste management.
- We observed staff in all surgical areas at the GH disposing of clinical, domestic and recyclable waste. Ward and theatre staff reported having access to domestic and recyclable waste bags. Senior staff told us that they had always segregated waste in this way to save money on incineration costs. This meant staff were following trust policy for the disposal of clinical, domestic and recyclable waste.
- Senior nursing staff we spoke with were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes legionnaires disease. Infrequently used taps and showers were flushed three times a week and recorded on a computer system to monitor compliance.
- Staff told us water used to wash patients was disposed of in hand wash sinks. This was not in line with Health Building Note 00-09: Infection control in the built environment 3.63 and 3.64. Contaminated fluids such as patients' wash-water should not be emptied down clinical wash-hand basins in adjacent ward areas. Disposal facilities should be provided in areas where

dirty wastewater is disposed (for example, dirty utility rooms and cleaners' rooms/areas for cleaning equipment). Staff were unsure what the correct procedure was and there were no signs above hand wash sinks advising staff not to dispose of patient wastewater in this way. This meant there was an increased risk of hand and environmental contamination.

Environment and equipment

- There were single rooms available for use on each ward. Priority for these rooms was given to patients who were particularly unwell or needed to be isolated because of infection.
- Resuscitation equipment, including emergency medicines, was readily available in all surgical areas, including theatres. A difficult airway trolley, providing additional equipment for emergency use, was also available in the theatre suite. Records showed staff checked all emergency equipment daily as in line with trust policy. We reviewed the records for previous months so we were assured this was a consistent practice. Matrons carried out monthly audits of the checking procedure for cardiac arrest trolleys. Re-stocking of resuscitation trolleys was carried out after use or in the event of out of date stock. A central store for equipment was available.
- Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made. We checked 10 pieces of equipment, for example; blood pressure monitors pumps and hoists; all had been appropriately tested and were within their service date. Electrical equipment we checked had been checked annually as per portable appliance test recommendations.
- Bariatric wheelchairs were available and staff would speak with the manual handling team if they required any further equipment, for example, specialist beds or hoists.
- Theatre staff reported having sufficient equipment to undertake their roles. For example, we were told theatre equipment for specialist surgical procedures was available at all times. We saw specialist equipment needed for an emergency being provided immediately in order to maintain patient safety.
- Clinical areas had limited storage for equipment; however, an equipment library was available. This stocked and repaired regularly used items of

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equipment. The trust carried out preventative planned maintenance on all equipment stocked in the equipment library. This included items such as syringe pumps and infusion pumps. Each ward had a set number of specific pieces of equipment that they used regularly these were topped up daily Monday to Friday. All returned items were further cleaned and serviced on return to the equipment library. Equipment was available out of hours through the portering team who had access to the equipment stores. All staff reported good access to equipment from the library.

- Control of Substances Hazardous to Health (COSHH) was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids and flammable liquids were not always stored in locked cabinets away from patient areas.
- The trust provided audit information from October 2015 stating that 92% of staff had been provided with the necessary information, instruction and training to ensure that they were able to use, transport, store and dispose of substances safely
- Ward sisters told us COSHH information was available on the intranet. However, they had no knowledge of any data sheets or information relating to what substances were on their wards and how they should be stored.
- On all wards, we saw oxygen cylinders stored on the floor in storerooms. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored in a purpose-built trolley in a well-ventilated storage area and cylinders should be chained or clamped to prevent them from falling over.
- There was no signage on the doors to indicate the storage of oxygen in these areas. Medical gases Health Technical Memorandum 02-01 (HTM02) guidance states warning notices should be posted prohibiting smoking and naked lights within the vicinity of the store.

Medicines

- Medicine errors, including those resulting in harm, were reported as part of the trust incident reporting process. Between March 2015 and March 2016, 15 of the 248 reported incidents related to medicines.
- Four ward areas within the surgical division had reported incidents related to medicines with cardiac

and thoracic surgery reporting the highest numbers. Reasons for raising incidents were largely due to prescribing omissions, or omission and delay in administration.

- Staff were able to discuss incidents where errors had occurred and describe the actions taken to help prevent a similar error. For example, medication charts were checked at all staff handovers to ensure missed doses or signatures could be identified immediately.
- A paper based medicine administration record chart was in use at this site. Patients allergies were recorded on this chart.
- Medicines interventions by a pharmacist were also recorded on the paper charts to help guide staff in the safe administration of medicines.
- We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date.
- The Trust had a self-medication policy, (this is a policy to enable competent patients to administer their own medications safely whilst in hospital).However, we found that this was not widely used and we identified a patient who had wanted to self-medicate who was unable to do so due to lack of the paperwork to facilitate this. This meant the patient was unable to maintain his independence by administering his own medications.
- We looked at the prescription and medicine administration records for 11 patients across two wards. We saw appropriate arrangements were in place for clearly recording the administration of medicines. Records showed people were getting their medicines when they needed them and no omissions were recorded on any of the charts reviewed.
- Nursing staff confirmed they had access to regular pharmacy advice. The pharmacists visited the wards daily Monday to Friday, to check prescription records and raise any queries. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- There were local microbiology protocols for the administration of antibiotics. The pharmacist monitored antibiotic prescribing to ensure patients were prescribed antibiotics in accordance with these protocols.
- Controlled medicines, (these are medicines controlled under the Misuse of Drugs regulations 2001, these legal controls govern how controlled medicines can be

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stored, produced, supplied and prescribed), on the wards and in theatres were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and these were in date and replaced by pharmacy when used.

- Disposal arrangements were also in place for expired medicines, or medicines, which were no longer required. Medicines were disposed of in sharps disposal bins or returned to pharmacy. There were denaturing solutions for use with controlled medications. Denaturing solutions render controlled medicines irretrievable and unfit for further use until they are fully destroyed by incineration.
- Intravenous fluids were stored in locked cupboards in treatment rooms on wards. This reduced the risk that intravenous fluids could be tampered with or accessed by unauthorised people. However, fluids containing potassium were stored in close proximity to other fluids resulting in a risk of selecting the wrong fluid.
- There were arrangements in place for the storage and management of medicines in some surgical areas, including theatres and recovery. However, some ward areas had small clinic rooms, and these rooms felt warm. There were no room thermometers available therefore we could not be assured that the temperature in these areas were safe for medication storage. This was raised with the senior pharmacy team at the trust during our inspection.
- On our unannounced visit, the clinic rooms at Glenfield Hospital (GH) had all been provided with room thermometers and a daily logbook to monitor temperatures. Where temperatures were above 25 degrees centigrade, staff were aware they must inform pharmacy immediately.
- On all of the wards we inspected, the temperature checks for the medication fridges were undertaken by the ward teams. Whilst current fridge temperatures were recorded, recordings of lowest and highest temperatures (over a 24-hour period) were not recorded. We could not be assured medicines were stored safely and consistently at the recommended temperature of between two and eight degrees centigrade. None of the nursing staff we spoke with told us they had received any training concerning how to check fridge temperatures. Action was taken at the time of the visit to address deficiencies in monitoring.
- During our inspection, the trust sent out a memorandum to all areas with a new medicines

refrigerator-checking sheet to be started immediately. At our unannounced inspection, a new fridge temperature-recording sheet was available and staff had been shown how to use the fridges in their areas, and how to report out of range problems.

Records

- Patient's individual care records were mostly written and managed in a way that kept patient's safe.
- We reviewed 12 sets of medical and nursing records. All patients nursing risk assessment documentation were completed appropriately. For example, falls, bed rails, malnutrition scoring and pressure ulcer assessments. However, care plans were not individualised for each patient. This meant care did not always meet the individual needs of the patient.
- Pre-operative checklists were completed which included a record of consent. These checklists ensure certain safety elements are completed prior to any surgical procedure. For example patient identification, allergies, correct consent and the time of last food and drink.
- Throughout the wards and theatres, we saw patient identifiable information was stored securely. The wards were in the process of being provided with digitally locked trolleys; this had improved the timeliness of completing medical records, as the doctor did not have to spend time locating a key to open a locked trolley. All the staff we spoke with were aware of their responsibilities for the safekeeping of records and confidentiality of patient information.
- Whiteboards, (for essential patient information), on each ward were usually behind the nurses' station. Full names were not displayed. This meant that patient confidentiality was maintained.

Safeguarding

- The trust had a safeguarding lead at executive level in addition to local named leads for children and adult safeguarding. All staff we spoke with were aware of the safeguarding leads and none reported any issues accessing the safeguarding leads.
- All staff we spoke with were clear about what constituted a safeguarding issue and how to escalate a safeguarding concern.
- Information received after our inspection showed as of June 2016 that cancer, haematology, urology, gastroenterology and general surgery (CHUGGS), critical

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Care, theatres, anaesthesia, pain and sleep (ITAPS), musculoskeletal and specialist surgery (MSS) and renal, respiratory and cardiovascular (RRCV) had training compliance in level two safeguarding children of 94%, and safeguarding adults of 96%. None of the staff we spoke with were able to tell us the level of training they had received. All staff thought the level of safeguarding training was pre-determined dependent on their role.

Mandatory training

- Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (level one and two), conflict resolution, safeguarding adults (level one), health and safety and, basic life support. Information received after our inspection showed, as at June 2016 training compliance in surgical clinical management groups (CMG's) was greater than 90% across all subject areas. Requested training data following our inspection was not split into specific staff groups.
- A formal system was used to monitor uptake and senior staff were seen to be proactive in prompting staff that needed to attend. Ward sisters and individual staff received an email approximately three months before training was required in order to allow time for booking it onto staff rotas.
- Staff told us they were given time to attend training sessions or complete on line training and we saw this in practice. Ward sisters at Glenfield hospital, (GH), told us they allocated 11.5 hours per off duty for staff to maintain their mandatory training.
- Staff we spoke with confirmed they were up to date with mandatory clinical training, which included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- Clinical staff were observed to following the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic procedures, operating room and recovery was managed safely. However, the use of this document was not effectively audited. Five patient notes were audited per month from an average of 1000. This small sample did not provide robust evidence that the trust was fully aware of its compliance.

- A National Early Warning System (NEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating. We saw NEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.
- The trust was rolling out the use of electronic observation devices (e-obs) to record patient observations. (A mobile device would be used by the nursing staff to collect and store patient observations, creating a score that can assist in making clinical judgments when treating a patient. This scoring can help indicate signs of deterioration for example sepsis and acute kidney injury. This enables a nurse to remain with the patient should their observations deteriorate, as alerts can be sent automatically to the responding teams who can then come and review the patient.
- During our inspection of this hospital, we reviewed 12 patient observation charts across four clinical areas. Nursing staff mostly adhered to trust guidelines for the completion and escalation of NEWS. However, not all observation charts had frequency of observations recorded. All charts reviewed had full observations recorded which included blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Pain scores were recorded on all charts reviewed. NEWS had been completed correctly at each time of recording the patient's observations. Of the patients requiring fluid balance charts, all of these were up to date and accurately calculated. Patients scoring on their NEWS were required to have further set of observations recorded within a set timescale for example from four hourly to one hourly. Of the 12 charts reviewed, all patients had observations performed in line with the trust 'escalation of NEWS monitoring in adult patients' with the exception of one patient who was not for escalation.
- We reviewed the observation charts for two patients who had scored a NEWS of three or above. Both patients were appropriately screened for sepsis in line with the sepsis pathway. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs.

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- Nursing and medical staff used the SBAR tool to frame conversations requiring a doctor's immediate attention and action. The tool consisted of standardised prompt questions within four sections (Situation, Background, Assessment, and Recommendation). This ensured staff shared concise and focused information and allowed staff to communicate assertively and effectively and reduced the need for repetition.
- Staff took the time to identify and respond to the changing risks of patients. Nursing and medical handovers were held each day on the wards to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most attention and allowed them to gain an oversight of the ward as a whole. A post ward round safety huddle was observed on ward F24 to update staff of any changes that may affect patient safety. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.
- The handovers were well structured and information discussed included; patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments. Deprivation of Liberty Safeguards (DoLS) are a set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests.
- Each ward at Glenfield Hospital (GH) had a 'hot board' (safe staffing board) at its entrance displaying planned and actual staffing. During our visit, all four wards met the requirement of 1:8 nurses to patient ratio.
- Information supplied to us by the trust from June 2016, reported an average staff turnover in surgery at GH of 15.2%. The trust recommended average was 10.2 %. Staff turnover refers to the number or percentage of workers who leave an organisation and are replaced by new employees.
- Information supplied to us by the trust from June 2016 suggested five whole time equivalent (WTE) vacancies for registered nursing staff and three WTE vacancies for healthcare assistants and other support staff across the surgical departments at GH. (Cardiac, thoracic, anaesthetics and orthopaedics).
- All staff reported the use of hospital bank staff rather than agency in order to provide cover by staff that knew the hospital. The average use of bank nurses in surgical areas at GH was 5.8% during the period April 2015 to March 2016.
- The highest use of agency nurses was in theatres and cardiac surgery both with 7% in the same reporting period. Ward sisters/charge nurses told us this was because of vacancies and sickness rates over the winter period.
- Vacancies in theatres and cardiac surgery were reported as four whole time equivalents (wte) from an establishment of 21 during the period April 2015 to March 2016.
- Sickness rates in theatres and cardiac surgery were reported at 5.7% during the period April 2015 to March 2016.
- The trust had a rolling programme of recruitment, including overseas. Staff at GH told us they had taken part in recruitment events in order to encourage new nurses to join the teams in the cardiac and thoracic wards.
- On the thoracic and cardiac wards, 26H and 31H there were four-bedded High Dependency Units for those patients deemed as requiring level one and two care. Level two care is defined by the Guidelines for Provision of Intensive Care Services (GPICS) as; patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. GPICS standards suggest 'Level 2'

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. Patient acuity and dependency data was collected using a nationally recognised safer nursing care tool. This tool measured the individual dependency of patients and calculated how many nurses were needed to care for them.
- Following a trust wide acuity assessment undertaken in June 2015 and January 2016, formal establishment reviews had been undertaken in each clinical management group (CMG). The reviews were led by the chief nurse and had full input from the deputy chief nurse, heads of nursing, head of midwifery, matrons and ward sisters/charge nurses. The outcome of this was to ensure 1:8 nurses to patient ratios on all surgical wards.

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patients require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care. At the time of our inspection, we observed staffing levels in line with GPICS guidelines.

- Essential information and guidance was available for all temporary staff including bank, locum and agency. A specific induction folder was used in the clinical areas for locum staff, 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures; ward orientation and electronic medicine administration. We saw these books in use on all of the wards at GH.

Allied Health Professional staffing

- Dietetics, physiotherapy and occupational therapy were available 9am to 5pm Monday to Friday. Where support was required from physiotherapy out of these hours an on-call system was in place.
- Speech and Language Therapy (SALT) were available 9am to 5pm, Monday to Friday. There was no weekend or bank holiday cover.
- Dedicated physiotherapy and occupational therapy staff were available in cardiac (Ward F31) and thoracic surgery (ward F26). Physiotherapy was provided 24 hours a day, seven days a week on Ward F26H thoracic high dependency unit (HDU) and F31H cardiac HDU.

Surgical staffing

- The trust wide percentage of consultants, registrars (middle-ranking hospital doctor undergoing training as a specialist), and junior doctors were similar to the England average. Consultant staffing at the trust was 43% compared to an England average of 41%, registrar grade medical staffing at the hospital 40%, compared to an England average of 37%. There was a lower number of middle grade staff at 7% compared to an England average of 11%. Junior medical staffing at the hospital was 10% compared to an England average of 12%. This provided a stable team of medical staff in surgery.
- Surgical doctors, registrars and consultants from all specialities were on call to provide advice and care 24 hours a day. Doctors and registrars were available on site during the day, including at weekends. Consultants were on site during the weekdays and were available to attend the hospital out of hours when necessary. An anaesthetist and a consultant surgeon told us on call staff were available when offsite within 20 minutes. This was in line with hospital policy.

- Handover took place daily, seven days a week for all surgical patients. The on call junior doctors and registrars had a 30-minute overlap in their shifts, which allowed for a handover of all admissions and any concerns regarding particularly unstable patients.
- A theatre meeting took place each morning attended by the anaesthetic team, theatre team, consultant and surgeon on call for the day to decide any changes to the lists. Medical handover for anaesthetics took place twice a day for theatres.
- Information supplied to us by the trust from June 2016 showed there were six wte medical staff vacancies between breast and cardiac surgery at GH. However, a recruitment programme was on going.
- In the reporting period, April 2015 to March 2016 there was an average locum usage of 5.3% throughout surgical services at GH. The highest use of locums was in cardiac and thoracic surgery with 7.1 and 7.6% respectively in the same reporting period. Medical staff told us the reason for the use of locums was due to a reduction in training posts. Health Education England (HEE) data showed there were only eight training posts available within this surgical speciality for 2015 throughout England.
- Essential information and guidance was available for all temporary staff including bank, locum and agency. A specific induction folder was used in the clinical areas for locum staff, 'temporary staffing local induction record log book'. Areas covered on the induction included; working procedures, ward orientation and electronic medicine administration

Major incident awareness and training

- Nursing and medical staff we spoke with were aware of the trust's major incident and continuity plan.
- The sister on ward F26 and a staff nurse on ward F31 were able to show inspectors where to find the major incident plan and could describe their responsibilities as part of it, in the event of a utilities failure or major incident.
- The theatre staff we spoke with were not aware any major incident exercises, had taken place in theatres during the past 12 months. This meant they had not had the opportunity to practice any scenarios in preparation for a real incident.
- However, the trust provided information in relation to training, 12 senior staff had attended the Glenfield Hospital (GH) evacuation workshop as part of

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emergency planning including nurses and administration staff. This was in order to ensure senior key people who would be involved in an evacuation of any part of the hospital were aware how the plan would be activated.

Are surgery services effective?

Good



The effectiveness of medical care services was good. Patients had good outcomes because they received effective care and treatment that met their needs.

We found;

- Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. We saw good use of patient pathways aligned to National Institute for Health and Care Excellence (NICE) quality standards.
- The outcomes for patients were mostly in line with, or better than the England average.
- We saw where patient's symptoms of pain were managed effectively in both ward and department areas. Staff were proactive in assessing patient's nutrition and hydration needs.
- We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff were qualified and had the skills they needed to carry out their roles effectively and staff were supported to maintain and further develop their professional skills and experience.

However we also found;

- Staff did not have a full understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and their use with patients that lack capacity.

Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered in line with national and best-practice guidelines. For example, the use of National Early Warning System (NEWS), complied with the recommendations within NICE guidance CG 50 acute illness in adults in hospital: recognising and responding to deterioration.

- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- We saw examples of policies and procedures, which were based on nationally recognised guidance. The inpatient care and risk document, completed for every patient, contained the malnutrition universal screening tool (MUST); this identified adults who were underweight or at risk of malnutrition. A nationally recognised screening tool was used to identify patients at risk of developing pressure ulcers and the 'diabetes foot screening assessment' was used to detect the development of foot problems in patients with diabetes.
- We saw completed MUST documentation in five sets of pre-operative patient notes on ward F24.
- Patients care needs were reassessed throughout their care pathway. Care and treatment was delivered in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal College of Nursing guidelines. For example on ward F26 and F31 we saw patients were reassessed immediately on return from theatre in order to ensure their post-operative safety.
- Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists guidance. We were told the trust had applied for Anaesthesia Clinical Services Accreditation (ACSA). This is a voluntary scheme for NHS and independent sector organisations offering quality improvement through peer review.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend patients with certain co-morbidities (multiple medical conditions) are reviewed pre operatively by an anaesthetist. Examples include age, heart disease (myocardial infarction and angina), and heart failure, ischaemic brain disease (stroke and transient ischaemic attacks).
- The majority of patients with multiple medical conditions or increased complications of anaesthesia were seen in a 'high risk anaesthesia' clinic. This ensured patients at high risk of complications were fully prepared for the procedure and an appropriate anaesthetic selected prior to surgery. For example,

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some surgical procedures were carried out under a spinal block eliminating the risk of general anaesthesia. We saw documentation and spoke with two patients who had attended this clinic.

- Day surgery patients mostly received care in line with the best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011.
- The Association of Anaesthetists guidance states it is best practice to have a dedicated telephone helpline for patients during the first 24 hours post day surgery. The day surgery unit did not have this in place. Patients were advised to contact a ward (depending on the surgical procedure) or their own GP if they had any concerns following discharge. A telephone advice sheet was available on wards to record calls received. However, these were not consistently stored in the patient record. This presented a risk to safety and continuity of care as all patient contact should be documented for each episode of care.
- During admission, comprehensive care pathways were in place for patients undergoing anaesthesia for surgery, including localised and general anaesthesia. Care pathways are multidisciplinary plans of anticipated care and timeframes. This meant there was a standard system in place for each patient admitted.
- The NHS institute for Innovation and Improvements professional standards in relation to enhanced recovery were being met in thoracic surgery. For example, patients were advised pre operatively on ways of improving recovery outcomes by stopping smoking and improving eating habits.
- An enhanced recovery procedure was in place for patients having lung, breast and cardiac surgery. Enhanced recovery is an evidence-based approach that helps people recover quickly following major surgery. We saw a copy of 'my lung surgery diary', which included information for the patient on what they could expect before and after surgery, and discharge information.
- Surgical staff were observed to be following the National Institute for Health and Clinical Excellence (NICE) guidelines for the prevention and treatment of surgical site infections.
- Across the surgical division, we saw there were arrangements in place aligned to the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. Examples included a

consultant-led service with consultant availability at all times for telephone advice, a dedicated surgical team free of elective commitments to cover emergencies and emergency theatre availability at all times.

- University Hospitals Leicester (UHL) followed NCEPOD, (National Confidential Enquiry into Patient Outcome and Death) guidelines for patients requiring emergency operations after 10pm. This meant patients, operated on after 10pm, were recovered in theatre and then returned to a surgical ward. UHL reported zero occurrences of patients staying in recovery overnight.

Pain relief

- Glenfield Hospital (GH) fully complied with all of the standards set out by the Faculty of Pain Medicines Core Standards for Pain Management (2015). For example standardised assessment tools and clear protocols for the management of acute pain by ward staff. The trust were working towards implementation of all recommendations, particularly those in relation to managing pain in the community. They also regularly liaised with other local pain services through the midlands pain forum.
- A dedicated pain management team covering the hospital could be contacted by bleep/pager. The team included nursing and medical staff and covered all three hospital sites. They were available 8am-5pm Monday to Friday, over the weekends this service was covered by anaesthetists. All patients who required major elective surgery were referred to the pain nurse pre-operatively who then visited patients following their operation.
- The pain management team used a variety of pumps to administer analgesia (pain relief) to specific localised areas. These pumps were reviewed daily and medication doses adjusted if the patient was experiencing pain. We spoke with three patients using these devices; they all reported an improvement in pain control and increased mobility because of a portable pump.
- Following surgery, appropriate pain relief was administered in theatre recovery. Pain control was discussed with patients pre-operatively and documented in the 'admission for adult surgery' documentation. We saw pain control information and heard discussion with patients on ward F26.
- National Institute of Health and Care Excellence (NICE) guidance 'Patient Group Directions (PGD)' (2013) were followed. This allowed registered nurses to supply

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prescription-only medicines to patients, without individual prescriptions. However, the trust currently used only one PGD for pain relief trust-wide. This was for paracetamol. This allowed for a timely response to some patients pain without having to wait for a doctor's prescription. The trust was considering using further PGDs to respond to patients requiring stronger analgesia.

- Ten patients on wards F24, F26 and F31 told us nurses responded quickly to requests for pain relief and staff returned to ask if their pain had been relieved. During our inspection, we saw nurses on medication rounds asking each patient about their pain and administering analgesia as prescribed. In all 12 medication records we reviewed pain relief medication had been prescribed and given appropriately.
- A Pain aid tool was available for patients with cognitive impairment; we saw these on all wards attached to the blood pressure machines. We saw a health care assistant on ward F24 using the pain tool to explain how pain was scored to a patient.

Nutrition and hydration

- Fluid balance charts were in place to monitor patients' hydration. We reviewed 10 fluid intake and output charts and found that all 10 were completed accurately. This meant that patients' fluid requirements were monitored accurately.
- All patients had their nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). The MUST tool calculates the overall risk of malnutrition. Patients were assessed as low, medium or high risk.
- An inpatient care and risk document was completed for all admissions. This included a section on nutrition and hydration. This was completed in all of the 12 care plans we reviewed and stated dietary requirements for example 'diabetic' or 'vegetarian', whether any special utensils were required and whether the patient had any difficulties swallowing.
- However, we saw patient individual food preferences were documented in seven out of 12 care plans. This meant patients likes and dislikes were not always accounted for.
- Nutrition care plans were in place for each patient where risks were identified. We reviewed two food charts on ward F26, both were fully completed.

- At Glenfield, hospital (GH) a dietician visited each ward monitoring general day-to-day enquiries. For example relating to surgical patients not eating post operatively. Staff told us that dieticians were easily accessible and responded promptly to referrals from nursing staff.
- Housekeeping staff handling food told us they had received food hygiene awareness training. However, nursing staff and ward sisters were also serving and preparing food (e.g. soup, toast); they told us they had not done any food hygiene training. The hospital policy Food Hygiene and Ward/Department Kitchens Policy 2016 and The Food Safety and Hygiene (England) Regulations 2013 require that all "food handlers" are trained and/or supervised and instructed in food hygiene. This meant staff were not adhering to regulations or trust policy.
- The trust wide Friends and Family Test, (FFT), scored satisfaction for catering at 77% (against the England average of 88%). The FFT is a single question survey, which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care.
- Patients told us that generally they were satisfied with the food provided at the hospital.
- Food was available on the wards throughout the 24-hour period. A range of diet choices was available including vegetarian, gluten free, kosher and halal. We saw housekeeping and nursing staff assisting patients with menu choices. Snack boxes were available for patients who missed a meal.
- Patients were given information about when they must stop eating and drinking before their operation. Depending on the surgical procedure, patients could drink up to two hours before surgery and eat up to four hours before surgery.

Patient outcomes

- In the National Adult Cardiac Surgery Audit Registry Data Validation (known as NICOR), for the period April 2012 – March 2015, a total of 3343 operations were performed during the period (National Average: 2465). A total of 138 procedures were excluded, leaving 3205 procedures for comparison. The risk adjusted inpatient survival rates were equal to the national average at 2.1%.
- The 2014 Lung Cancer Audit found the trust discussed a higher percentage of patients at multidisciplinary team

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meetings than the England average of 95.6% at 99.6%. The trust also had a higher percentage of patients receiving a CT scan before bronchoscopy at 97.3% compared to the England average of 91.2%. Trust performance therefore met the required 95% standard in both areas.

- On average elective and non-elective patients spent a similar time in surgery services when compared to the national average. Elective hospital admissions occur when a doctor requests a bed be reserved for a patient on a specific day. The average length of stay for elective patients at this hospital from April 2015 to March 2016 was 3.4 days, compared to 3.3 days for England. For non-elective patients (emergency), the average length of stay was 3.3 days, compared to 5.1 for the England average.
- The trust was an outlier nationally for the rate of readmissions within 30 days of discharge. In response, the trust had made a commitment for 2016/17 to reduce readmissions within 30 days to below 8.5%. The trust plans to reduce readmissions included, monitoring readmissions through their governance structure, focussing discharge resources on those patients at a higher risk of readmission and addressing clinical variations in consultant re-admission rates. The new project had been implemented throughout June 2016.
- Trust results from the patient reported outcome measures (PROMs) April 2015-March 2016 for groin hernia, hip replacement, knee replacement and varicose veins were similar to the England average. PROMs is data collected to give a national-level overview of patient improvement after specific operations
- There were no current mortality outliers relevant to surgery. A mortality outlier is when there have been a higher number of deaths than expected for a defined condition. This meant there had been no more deaths than expected for patients undergoing surgery at this hospital.
- For the period March 2015 to February 2016 patients at this hospital had a higher than expected risk of readmission for elective admissions (planned), with the exception of cardiac surgery, patients in thoracic surgery and general surgery when compared with the England average. For non-elective admissions (emergency), with the exception of thoracic surgery, patients in cardiac surgery and breast surgery, patients had a lower than expected risk of readmission when compared with the England average.

Competent staff

- The trust had systems in place to ensure that the registration status of qualified doctors and nurses' had been renewed on an annual basis. There was a nominated responsible officer for medical revalidation. Nurses told us there were learning events to help with revalidation.
- Staff told us they attended a trust wide corporate induction and local induction when they commenced employment at the trust.
- The trust target for attendance at the corporate induction was 95%. Ninety-two per cent of relevant staff, within the clinical management groups (CMGs), had attended the trust corporate induction in the last year, which was below the trust target.
- The trust recruited nurses from Europe including Spain, Portugal, Italy and Greece. These nurses were given a comprehensive 12-week induction including lessons to develop their English language; they were supernumerary on the wards to enable them to become familiar with nursing practice in England. During specific induction, these staff wore green name badges. At the end of the induction, they had to complete and pass a medicines management assessment before being allowed to work independently.
- Ward F26H had a four-bedded high dependency unit (HDU). Staff working on this unit received enhanced training which included for example; non-invasive ventilation (NIV), early warning scoring (EWS), chest drain management, tracheostomy care and care of arterial lines. Information reviewed during our inspection showed 16 out of 20 staff had completed HDU competencies for ward F26H. Senior staff in this area told us the off duty was arranged to ensure at least one member of staff who was HDU competent was on duty at all times.
- A specific induction folder was used on the wards for bank and agency staff called a 'temporary staffing local induction record log book'. Areas covered on the induction included working procedures, ward orientation and electronic medicine administration. The logbook on the two wards we looked at was completed sufficiently to indicate bank and agency staff had been orientated to the ward or clinical area.

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- Within the surgical division at Glenfield Hospital (GH), from April 2015 - March 2016, completed staff appraisals were reported to be 91%. This was below the trust target of 95%.
- All the staff we spoke with described their appraisal as a positive experience, which enabled them to identify their learning needs for the following year. For example, mentor training and assistant practitioner (AP) training. We spoke with a health care assistant on ward F26 who had been encouraged and supported by the head of service to undertake the AP training.
- Staff told us whenever possible they were allocated time to attend training sessions or complete on line training and we saw this in practice. During our unannounced inspection, theatre staff arranged training at short notice after the cancellation of an operating list.
- Advanced nurse practitioners (ANPs) were able to request ultrasounds and other diagnostic tests. This ensured patients had timely access when medical staff were unavailable to request this procedure. One member of staff at GH told us, "everyone should have an ANP the support to the team is incredible". Additional nurse training and education has enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate.
- Medical and nursing staff commented on the benefits of having an advanced nurse practitioner available on the cardiac and thoracic wards. This ensured there was always someone around to call on in an emergency
- Four out of five junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. We observed good interactive learning taking place during a patient ward round between the consultant and a junior doctor and an ANP.
- Junior doctors told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- All of the patients who spoke with us reported a high level of confidence in medical and nursing staff with regard to their knowledge and their skills.
- The cardio/thoracic surgeons at GH participated in cardiology multidisciplinary teams (MDTs) at surrounding District General Hospitals and held clinics at least once a month when space was available.
- We observed physiotherapy staff assisting with patient therapy sessions encouraging mobilisation and self-care activities.
- Dietician staff contributed to daily MDT meetings, which included the nurse in charge, a doctor and the bed co-ordinator. The MDT discussed each patient's condition and progress.
- Occupational Therapy staff told us there was effective communication and partnership working between the surgical/orthopaedic MDT. They met regularly to identify patients who required visits or to discuss any changes to the care of patients.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams, services or hospital sites, Surgery services was based at all three hospital sites of the trust. MDT working within specialist services for example, the pain team and the thoracic nurse specialists involved linking between the sites. All staff we spoke with felt that the services were available in a timely way despite not necessarily being based at the general hospital site.
- When patients were discharged, communication was generated electronically and printed off to be posted to the patients GP. This detailed the reason for admission, any investigation results and treatment undertaken.

Seven-day services

- Access to an emergency theatre was available seven days a week if required. A dedicated cardio-thoracic theatre team was on call 24 hours a day seven days a week and could be in theatre within 30 minutes of being called. This was in line with the trust policy.
- Surgical consultants worked an emergency on call rota, seven days per week. A consultant was on call 24 hours a day Monday 8 am to Friday 5pm then another one Friday 5pm to Monday 8am. This maintained continuity for patients within the clinical management groups (CMG's) and on the ward. Ensuring patients were reviewed over weekends and bank holidays.
- The medical doctors we spoke with told us there was good access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support

Multidisciplinary working

- There was good multidisciplinary (MDT) working across surgical areas. All three-hospital sites at the trust were trialling a teleconferencing system to improve MDT working within orthopaedics. This was to be used to support other NHS trusts that used these services.

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clinical decision making. For example, interventional radiology had an on call system for covering trust sites including nurses and a vascular and non-vascular radiologist.

- Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.
- Ward based pharmacists visited the wards four to five times per week to review medication charts and a pharmacy on-call system was in operation at weekends and out of hours.

Access to information

- Information needed to deliver effective care and treatment was not always available to relevant staff in a timely and accessible way. Some staff told us medical notes were often missing when patients were added to theatre lists at short notice. However, staff did not accurately record this or report it as an incident through the trust incident reporting system.
- Information we received after our inspection identified no incident reports specifically in relation to missing patient notes at Glenfield Hospital (GH). However, because staff were not always reporting missing notes as an incident we were not assured the trust were fully aware of the extent of the problem.
- Nursing staff on ward F24 told us procedures were usually cancelled if there were no medical notes unless the surgeon felt the procedure was low risk then the operation would go ahead.
- Policies and procedures were accessible on the trust intranet. Staff told us they knew how to access policies and we observed a member of staff searching for a policy.
- We saw a range of up to date policies and procedures on the hospital intranet relating to patients with diabetes, these included pre and post-operative procedures.
- Information and guidance regarding specific procedures or conditions was available through the trust's intranet. For example diabetes management pre and post operatively. We saw information had been printed and included in the nursing notes to use as a guide.
- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.

- We saw in theatres where an online, real-time communication system was used. This allowed staff to track patient journeys through theatres and contributed to the management of theatre schedules. However, staff told us that real time inputting of data was sometimes not possible due to a lack of computers particularly in anaesthetic rooms. This meant we could not be assured theatre lists were accurate and up to date. However, staff told us they did not record this or report it as an incident through the electronic incident reporting system.
- Some elective surgery patients attended the preoperative assessment clinic where a number of investigations could take place, in an adjacent area. Comprehensive risk assessments were completed in the inpatient care and risk document. This meant all the information to deliver effective care and treatment was readily available to staff.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- GPs had direct access to the medical staff and could speak to a surgical consultant or other senior doctor for advice on the phone.
- Doctors we spoke with told us that overall referral letters, in triage areas, from GPs were comprehensive and available with the patient; this meant that informed decisions could be made about on-going care and treatment.
- Discharge summaries were sent to the patient's general practitioner (GP), on discharge to ensure continuity of care within the community. Summaries were sent on the day of discharge by e-mail, post or given to the patient for them to hand to their GP. The discharge letter detailed the reason for admission, any investigation results and treatment undertaken

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they understood the relevant consent requirements of legislation and guidance and had access to the trust policy and procedures for consent.
- Where patients' had capacity to consent, consent was sought in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options about their care and treatment. We

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observed staff asking for consent both verbally and in writing. On checking five patient records (patients with capacity to consent), we saw copies of signed consent forms, which had been completed appropriately.

- Six patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and verbally consented to blood tests and scans.
- There were no patients at GH during our inspection requiring consent form four (a form used for the consenting of patients who lack capacity)
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training and updates were included as part of safeguarding training. However, most of the staff we spoke with had limited knowledge concerning MCA assessments. None of the nursing staff we spoke with felt they received sufficient training on undertaking MCAs. When questioned they did not understand who would carry out the assessment or when.
- We spoke with five nurses on the four wards we visited none of them could explain who would carry out an MCA assessment or when it would be required.
- During our inspection of this hospital, we saw no patients receiving surgical care who required a deprivation of liberty safeguard.

Are surgery services caring?

Good



The care provided to patients in surgical care services was good.

We found;

- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in their care and treatment.
- We observed staff positively interacting with patients and they were treated with kindness, dignity, respect and compassion while they received care and treatment. Feedback from patients was positive about the care and treatment they had received.
- Patients were involved and encouraged to be active partners in their care and in making any decisions.

Compassionate care

- The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service, they have received to friends and family who need similar treatment or care. The overall FFT response rate for surgery was 41% for the period July 2015 to June 2016 with response rates varying between 22% and 60% across the surgical wards. The England average response rate for the same period was 30%. Ward F31 consistently scored well: 95-100% of monthly respondents would recommend the ward, scoring 100% in nine of the 12 months.
- Seven Patients and three relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff
- During our inspection, we observed staff were kind, had a caring, compassionate attitude, and had positive relationships with patients using the service and those close to them. Staff spent time talking to patients. During lunchtime, we observed patients being provided with support. We observed staff were kind and respectful when supporting patients to eat and drink taking time to enable patients to eat their meals.
- We saw patients treated with care, compassion and respect as we followed them through the peri-operative pathway.
- We observed post-operative recovery nurses visiting patients before their operations to support them through the process. One patient who suffered a phobia of needles told us they were “wonderful and supported me when I needed it most”.
- We observed staff caring for a distressed relative in the theatre suite, offering them support and re-assurance as the patient had gone into theatre for surgery.
- We saw a letter from a patient on ward F31 highlighting the compassion and professionalism of all the staff. “Every single member of staff from Consultant, Registrar, Nurses, and Ancillary etc. were absolutely excellent in their individual roles and deserve the highest credit anyone could ever give”.
- Two patients on ward F24 had nothing but praise for all of the staff on the ward and in all the departments, they had visited prior to the surgical procedure.

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- We spoke to the thoracic nurse specialists who are passionate about the patient being at the very centre of everything. Patients join every year to discuss their care and ongoing treatment at a special day organised by the team.

Understanding and involvement of patients and those close to them

- We spoke with two relatives. They all told us staff were approachable if they needed to ask any questions. Staff were aware of patient confidentiality and told us they always checked with the patient if they were unsure of who was making the request.
- All members of the multidisciplinary team explained care and treatment in a way that could be understood. We observed a physiotherapist speaking with a patient and their relative to explain about the chest physiotherapy required after their operation and how important it was to reduce the risks of a chest infection.
- Staff spoke in a quiet calm manner to patients explaining what was happening to them and what was going to happen next.
- Patients told us they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them, doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- Information about surgery was shared with patients, and patients were able to ask questions. Patients and relatives said they were kept informed and felt involved in the treatment received.
- We saw documentation and spoke with two patients who had attended this clinic. They were 'put at ease' by the consultation and felt more informed about the risks involved.
- A recovery practitioner visited patients on the day of surgery to meet them and attempt to allay any fears they may have. This provided an opportunity to meet a member of the team that would be in recovery after the operation and improve continuity of care. Patients and staff told us this was a new initiative. We spoke with three patients who thought this was a 'great' idea.

Emotional support

- Chaplaincy services provided spiritual and religious support for patients and relatives and were accessible to staff if required. The chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains.
- A designated bereavement service was available at the trust to provide a sensitive, empathetic approach to the individual needs of relatives, at their time of loss. The bereavement services team produced an information leaflet to assist relatives/carers during the early days of bereavement.
- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Patients and staff had access to clinical nurse specialists across the surgical areas. For example, we saw that there were specialist nurses for thoracic, breast care and the acute pain team.
- We saw patients treated with care, compassion and respect as we followed them through the peri-operative pathway.
- We observed staff caring for a distressed relative in the theatre suite, offering her support and re-assurance as her husband had gone into theatre for surgery.
- The resuscitation officer provides pastoral care and advice for teams around the hospital post cardiac arrest to help them de-brief the incident.

Are surgery services responsive?

Good



We found the responsiveness of medical care services to be good.

- Patient's needs were met through the way services were organised and delivered.
- The majority of surgical specialties met or exceeded the 90% target of patients being seen within the 18 week referral to treatment target.
- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.
- It was easy for patients to complain or raise a concern. Posters and leaflets were available in the wards and clinical areas these allowed members of the public to identify how they could raise a concern or make a formal complaint.

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- There was a proactive approach to understanding and meeting the needs of individual patients and their families and services were planned and delivered to meet the needs of local people with direct access to specialist cardio/thoracic services.
- Evidence collected showed that there were no mixed sex breaches in the surgical specialities, that the average length of stay was better than the national average and that the number of cancelled operations remained low.
- Patients had access to a wide range of resources and materials, both online and in paper formats, which were individualised and tailored to their needs. One good example of this was with enhanced recovery programmes.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the patients it served and acted on these to plan, design and deliver services. For example, services include early contact and intervention pre-operatively with the cardiac and thoracic nurse specialists at Glenfield Hospital (GH).
- The trust engaged with internal and external stakeholders including patients, governors, members, partners and staff to plan services. For example 'Better care Together' the Leicester, Leicestershire & Rutland (LLR) health and social care teams discussed plans for an integrated, high quality service, delivered in local community settings where appropriate. Amongst other things, they plan to address services that are geared towards responding to a crisis in order to develop services that help to prevent and manage conditions before problems occur.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally. For example, Glenfield hospital, (GH), was the base for the regional cardio-thoracic unit. They provided a specialist service for coronary artery bypass grafting and heart valve replacements.
- The cardio thoracic unit served a population of two million and was a secondary and tertiary referral centre for adult heart surgery. The Society of Cardiothoracic Surgeons in England has recognised the unit as the eighth largest unit in UK, out of 38 other units performing adult cardiac surgery.
- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was limited.
- Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities to reduce anxiety and disorientation in the patient.

Access and flow

- In June 2015, the admitted and non-admitted operational standards were abolished, and the incomplete pathway standard became the sole measure of patients' legal right to start treatment within 18 weeks of referral to consultant-led care.
- The trust wide data for June 2016 showed that the majority of specialties met or exceeded the 90% standard of 90% of patients meeting their RTT.
- Nine theatres were available at this hospital providing emergency and elective surgery. Theatre utilisation (use) was reported to be high for January 2016 to March 2016. Theatre two had consistently high theatre usage across all three months with 70-84%. Theatre 9 had the highest monthly usage of 95% (January 2016).
- The matron in theatre was responsible for scheduling operations. A team leader worked across the theatres every day to recognise and trouble shoot problems such as capacity, overruns and staffing issues.
- Senior staff told us they made decisions about whether to cancel operations the day before the operation wherever possible. Surgical operations were graded one to three; those graded three were of lower priority and more likely to be cancelled. Patients with cancer were graded one and complex operations requiring surgeons from two specialities were grade two.
- Information from NHS England showed the total number of elective operations in University Hospitals Leicester, (UHL) cancelled on the day between January and June 2016, was 854. All but 92 of these were rescheduled within 28 days.
- Cancelled operations as a percentage of elective admissions performance was in line with the England average at this trust (0.8% -1.4% for the reporting period April 2015 to June 2016).
- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear

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guidance to staff regarding how to proceed when bed availability was an issue. Bed capacity meetings were held three times daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability. Ward F34 had been identified as an admission and discharge area for patients on ward F31. This meant that patients with lower dependency (new admissions or ready for discharge), could be moved from the main ward to accommodate patients coming from theatre or the high dependency area.

- The trust had procedures in place for surgical outliers. Outliers are patients cared for in an area outside of their speciality (for example, surgical patients on a medical ward). During our inspection, there were no surgical outliers. Staff on surgical wards told us during the winter they were often full with medical outliers. However, during our inspection there were no medical outliers.
- Bed occupancy at GH was 82% for April 2015 to March 2016. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients.
- Wards and departments included single-gender accommodation, which promoted privacy and dignity. The trust performance reports from April 2016 showed there were no reported times when male and female patients had been treated in a mixed area at this hospital between March 2015 and April 2016.
- The majority of patients admitted to Glenfield hospital were admitted from a waiting list as planned admissions for theatre. Patients were also seen in clinics and dressing clinics post operatively and could be admitted for wound management. The breast ward 24 conducted a daily dressing's clinic Monday to Saturday, any patient requiring admission from this clinic could be admitted directly to the ward subject to bed availability.
- For the period April 2015 to March 2016 the elective surgery average length of stay was higher than the England average, with cardiac surgery (GH 10.1 days average 8.7) and thoracic surgery (GH 6.4 days average 5.3) being the reported elective specialties to be above the average. Breast surgery length of stay however, was below the England average (GH 1.4 day's average 1.6).
- Non-elective surgery average length of stay for the same period was below the England average in all three specialist surgical areas at GH. (Cardiac 11.1 days average 12.5, thoracic 6.5 days average 7.9 and breast 2.7 days average 3.5).

Meeting people's individual needs

- The trust provided a comprehensive interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Information could be translated into different languages on request. Large print and easy read material was available on request. The three most commonly requested languages for both written and spoken translation were Gujarati, Punjabi and Polish. The trust had an interpreting and translation policy. Staff we spoke with were aware of this service and the policy.
- During our inspection, we noted very limited signage in different languages to enable non-English speaking patients and visitors to find their way around the hospital site.
- The trust offered pastoral, spiritual and religious support to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains, as well as a non-religious carer. Volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish supported the team. A 24/7 on-call service was provided and where possible a representative of the patient's own faith attended.
- The hospital had a chapel and prayer room (with washing facilities). Patients we spoke with were aware of the prayer rooms available to them.
- The Trust told us they liaised with local faith representatives through the chaplaincy and through representation on the trust's equality advisory group. This group advised on various faith issues including modesty and patient food.
- All patients were asked about their religious and spiritual preferences on admission and we saw evidence of completed nursing care documents to support this.
- Nursing care documents also contained an 'about me' section. This section captured general information about the patient such as sleep and rest patterns, communication and personal hygiene and allowed the patient to express any personal preferences. This document was especially useful in caring for patients living with dementia.

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- There was no system within the trust for identifying if a patient was blind or deaf and the trust did not monitor the numbers of blind or deaf people treated at the hospital. This meant that these patients may not receive care tailored to their individual needs.
- The trust was able to identify patients with learning disabilities through an electronic flag on the patient record system. This enabled the trust to monitor the numbers of patients with a learning disability attending. This information allowed the trust to tailor services according to patients' individual needs. On receipt of notification of an admission, the learning disability specialist nurse contacted the ward to discuss the patient's individual requirements. Staff on all wards were aware of the Learning Disability Liaison team and contacted them if they had any questions or concerns.
- Information provided by the trust reported between April 2015 and March 2016, 550 patients with a learning disability had used hospital services. The average number referred to the learning disability specialist (LDS) nurse per month was between 15 and 25. This meant on average 43% of patients with a learning disability were referred to the LD nurse. The trust did not provide any evidence of audit of this service in order to identify how many patients within surgery services had been referred to the learning disability specialist nurse.
- All patients with a learning disability were initially assessed using standardised nursing and medical documentation. Some patients had their own hospital profiles, (information booklets about their daily lives and their likes and dislikes), and were asked to bring them into hospital with them.
- Ward and theatre staff described adjustments which could be made for patients with learning disabilities. These included single rooms with facilities for relatives or carers to stay overnight, being first on the theatre list, relatives staying with patients until they had received their anaesthetic, being given greater time and aiming for consistent nursing staff.
- We did not observe any episodes of care in relation to this service during our inspection of Glenfield hospital (GH)
- The Trust was committed to the implementation and delivery of service improvements for people with dementia in Leicester's Hospitals. Person centred care was individualised to meet the specific needs of each patient using the 'Know me Better' patient profile. Open visiting was available to carers of patient's living with dementia. Policies were in place to reduce the number of ward transfers for patients living with dementia.
- We saw all patients had a board on the wall above each bed which displayed key information about their care needs, and included symbols indicating whether a patient had significant communication difficulties.
- All emergency admissions of patients over 75 years were screened for dementia as part of the admission process. Clinical and cognitive assessments were undertaken as part of the dementia care pathway. Care pathways are multidisciplinary plans of anticipated care. The trust had no dementia specialist nurses. However, there were dementia nursing sisters who worked within the corporate team leading on practice development and improvements and a dementia 'Champion Network' of staff with a particular interest supported patients with dementia.
- Patients and carers were signposted and had access to charitable organisations for additional support and information.
- Patient led assessment of the care environment audits (PLACE) are assessments carried out by local people going into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance and dementia facilities. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The 2015 PLACE scores for Glenfield Hospital showed the hospital scored lower than the England average for four out of the five areas. However, facilities for patients living with dementia equalled the England average at 72%.
- All ward areas had bathroom and toilet signage in order that patients living with dementia could assist themselves to the toilet where appropriate. Ward areas were also being painted in bright colours to help patients identify which bay they were in.
- Wheelchair access was good throughout the hospital. Disabled toilets were located at frequent intervals and were clearly signposted.
- The trust used the national NHS e-Referral Service system (previously known as choose and book) to assist patients in making, changing and cancelling appointments.
- When attending the pre-operative clinics all patients were given an information pack to take home with them

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which included pre-surgery high calorie drinks, information on quitting smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving. This was to ensure patients were as fit as possible prior to the surgery.

- In response to a patient group idea, the thoracic nurse specialists and ward F26 had developed a patient information diary that was given to patients. The 'my lung surgery diary' had information for patients and relatives about pre admission, hospital stay and post admission. For example information on enhanced recovery, visiting times and discharge planning. In order to increase patient motivation there was a diary section in the middle for patients to complete on each post-operative day. Patients told us this helped them identify how far they had recovered after their initial operation.
- There was limited accommodation at all three sites for relatives to stay if they lived out of area.
- Staff told us it was possible for relatives to stay overnight; the patient could be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities when relatives or carers stayed overnight in order to reduce anxiety and disorientation in the patient.

Learning from complaints and concerns

- We spoke with ward sisters about the management of complaints on the wards. We were told ward staff would speak to anyone raising a complaint at the time they raised it. The aim was to try to resolve the problem or complaint at the time it was raised.
- We were given examples where staff had managed complaints locally and telephoned patients and their carers to discuss their complaint and the learning taken from them. However, ward staff told us that some complaints raised by patients that were dealt with locally were not documented. This meant themes and trends could not be properly evaluated.
- 'Message to matron' cards and boxes allowed patients and relatives to make comments or raise concerns. Where possible these were dealt with locally. Patients and staff told us they felt this was a good idea and often the matron would visit patients prior to discharge in order to address concerns raised.
- Posters and leaflets explaining how patients could complain were clearly visible around the hospital.

Pre-operative information packs also contained information about how to make a complaint. The trusts patient information and liaison service (PILS) was located on this hospital site. Leaflets were available for patients explaining how PILS could assist in managing complaints. Patients and visitors told us they would feel comfortable making a complaint, as nursing staff were approachable and understanding.

- Between March 2015 and April 2016, there were nine complaints in surgery services at this hospital. Themes included the attitudes of staff, poor medical and nursing care or treatment. For example, a patient on ward F34 made a verbal complaint to staff during our inspection relating to communication and rescheduling of surgery. The staff nurse re-assured the patient and sought the assistance of a more senior colleague.
- Most staff told us they received feedback from complaints and concerns at staff meetings or through the monthly ward newsletter. We were shown staff newsletters that confirmed this.
- Staff on ward F31 described taking part in a daily 'safety chat', this was used by the senior nursing team to give staff information about complaints and concerns. They had developed this idea as ward meetings were generally poorly attended.

Are surgery services well-led?

Good



The leadership of surgical care service at this hospital was good.

We found;

- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- Departmental governance and risk management arrangements were mostly effective and as such able to protect patients from avoidable harm.
- There was a vision and strategy for this service and whilst it was strategic, staff were able to describe this to us during our inspection.
- Staff were consistent in delivering care and demonstrating behaviours in line with the trust vision and values.

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- Staff satisfaction was consistently positive with staff reporting good support at a local level. Staff were engaged and empowered to raise concerns where necessary.
- Staff reported good nursing leadership from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of nursing were visible and provided a good level of support.

Vision and strategy for this service

- Surgical care was provided at Glenfield hospital, (GH), as part of four Clinical Management Groups (CMG), Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS), Critical Care, Theatres, Anaesthesia, Pain and Sleep (ITAPS), Musculoskeletal and Specialist Surgery (MSKSS) and Renal Respiratory and Cardiovascular (RRCV).
- University Hospitals of Leicester NHS Trust had a detailed five-year integrated business plan, which covered 2014 to 2019. A two-year 'Integrated Annual Plan' was in place within CHUGGS with detailed plans of how the service intended to meet the increasing demands of the local healthcare economy. The plan, whilst ambitious, appeared to focus largely on the strategic direction of the service. For example to provide services seven days a week and to continue surgical emergency ambulatory care service to support a reduction in length of stay, better outcomes for patients and supporting the emergency process.
- The CMGs had individual five-year strategies that were linked to the trust's strategy, aims and objectives. Each CMG had its own strategy. The strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.
- The trust vision was to deliver 'caring at its best' for everyone who visited Leicester's Hospitals. Staff were involved in developing the five values to work by. For example, 'We treat people how we would like to be treated', 'we are one team', and 'we are best when we work together'.
- We found the majority of staff were able to articulate the values of the trust and the CMG. Staff displayed them in their daily work and we observed them putting patients first by working as a team, leading and listening, striving for the best and trying to make a difference.

Governance, risk management and quality measurement

- A risk register was held within surgery with 27 risks identified. Risks included a description, controls in place to mitigate the risk and, a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register. For example at GH related to the risk of cross infection in patients screened and not screened for MRSA. Actions to reduce this risk included staff education, the use of new faster screening techniques and managing unscreened patients in separate areas.
- CMG's held monthly quality and safety board meetings. We reviewed five sets of meeting minutes and noticed good levels of attendance. There was evidence of key themes around incidents and lessons learnt, complaints and a review of risks in CMGs, however, there was limited evidence of lessons learnt being shared between CMGs.
- Where incidents had been identified, they had been investigated. This included undertaking external reviews. Recommendations were made and changes implemented however, training relating to the changes did not always follow in a timely manner. For example a delirium tool was developed at the Leicester General hospital following a never event, but staff had no training on how to use it so were unable to explain it to us during our inspection and were not using it effectively to assess patients.
- Staff also reported not consistently raising incident reports in relation to missing medical notes.
- Individual CMGs identified different risks, incidents, and complaints within their areas but we did not see evidence to suggest that the CMGs worked together to share information and learning. This meant that opportunities for learning across surgery services within this Trust were limited. Information was shared through a network of meetings. Ward sisters attended monthly professional forum meetings. Main points from the meetings were cascaded to staff through ward meetings or ward bulletins. We saw copies of ward bulletins and staff described to us the type of information they received. The trust provided minutes of the professional forum meetings for each clinical management group. These all included topics relating to patient safety, recruitment, and changes to local guidelines/policies.

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- Nursing staff reported a good escalation plan for governance arrangements within this hospital. Examples included monthly sisters meetings at Glenfield Hospital, monthly ward meetings, matron involvement in monthly mortality and morbidity meetings and involvement in review meetings for falls and hospital acquired pressure ulcers.
- There was awareness from the service leads regarding the concerns that we had identified as part of the previous inspections. Safety, availability and suitability of equipment had been identified as a regulatory breach in January 2014 with dirty equipment found on wards. During this inspection of the surgical areas at GH, no dirty equipment was found.

Leadership of service

- Leadership of the four CMG's responsible for surgery was provided by a Head of Nursing, a Clinical director and, a Head of Operations.
- Staff told us they felt senior staff and managers were visible, approachable and supportive and they received appropriate support to allow them to complete their jobs effectively.
- Matrons and managers of individual CMG's were covering cross-site. Staff we spoke with did not feel this was a problem as matrons informed them of which sites they would be at and were available by telephone.
- All staff explained they would be happy to approach senior staff to raise concerns and the issues would be dealt with in a timely manner. However, some staff felt they would like more information on the plans for changing the activity at the three UHL hospitals. Staff said 'the dates for implementation kept changing so they never knew where they were'.
- Ward leaders and matrons spoke of ward staff with pride. We observed an obvious mutual respect amongst staff, ward leaders and matrons.
- Without exception, staff we spoke with were consistently positive about local ward leadership across all areas in surgical care services at this hospital. Staff told us ward leaders were "passionate", "very visible", and had an "open door" policy.
- All staff on ward F26 could not speak highly enough of the team and its leadership, particularly the head of service and the ward sister. The nurses were all encouraged to be involved in the day-to-day running of the ward.

- Junior doctors told us they felt supported and there was always a senior member of staff to ask for support.
- All staff, both medical and nursing, were aware of the trust whistleblowing policy. Staff told us they felt listened to and felt empowered to raise concerns.

Culture within the service

- The NHS Staff Survey 2015 saw the percentage of staff recommending the trust as a place to work or receive treatment as higher than the 2014 survey at 3.6%. This was slightly lower than the national average of 3.7%.
- In five out of eight questions relating to job satisfaction, the trust scored better than the national average for other NHS trusts 91% of staff felt that their role makes a difference to patients compared to 90% as a national average.
- Most staff felt respected and valued. All members of staff we spoke with were proud to work in the trust and they spoke positively about teamwork and the care they provided to patients.
- Without exception, all staff at GH displayed a great sense of pride in relation to how they supported patient care. For example, the breast, cardiac and thoracic specialist nurses supported patients throughout their whole hospital journey and beyond.
- Staff conveyed a strong open and honest culture in all areas visited during our inspection.
- Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers. However, some staff were unsure of what exactly a reportable incident. For example missing medical notes and environment concerns relating to medicine storage or pre-assessment areas.
- The senior managers within the surgical division had high praise for their staff and recognised the challenges staff within the surgical division faced especially with the increasing demand on surgery.
- Staff felt supported to develop their skills and progress their careers. Many staff we spoke to had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.
- Duty of candour briefing sessions had been held in surgery for all levels and types of staff groups. Roadshows were undertaken at each hospital site to raise awareness of duty of candour. A duty of candour slide had been added to the complaints e-learning module that all staff were able to access via the

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electronic trust-training portal. A duty of candour slide was also included on the trust induction programme for all new starters and on the medical directors' induction slides for new trainee doctors to the trust.

Public engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at the professional forums and meetings and within wards and teams. Patient experience, including compliments and complaints, and the results of the FFT were displayed within the wards on 'how are we doing' notice boards.
- Message to matron' cards and boxes, were available in all ward and clinical areas to encourage the public to comment on services provided. 'You said, we did' posters were visible however; completion of them was not consistent.
- The Trust engaged with local faith representatives through the chaplaincy and through representation on the Trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- The introduction of patient experience days in thoracic surgery had led to the development of the 'my lung surgery diary'. This engaged previous patients in developing new initiatives for current and future patients. The second day was due to be held after our inspection.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations.

Staff engagement

- All staff we spoke with at GH responded positively to an initiative known as 'Listening into action'(LiA)

- LiA is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of the organisation in a way that makes them feel proud. Staff showed enthusiasm for this initiative and told us they were given the opportunity to come up with ideas to improve patients and staff experience.
- In the University Hospital Leicester, UHL, pulse, check survey (short engagement surveys sent out several times a year. They help trusts to measure engagement more frequently) there had been an increase in positive findings in 8 out of 16 measures including quality and safety of patient care and recommending the trust to family and friends. There were three measures, which showed a reduction in satisfaction including effectiveness of communication with senior managers and staff feeling organisational structures and processes help them to do their jobs.
- The trust recognised the hard work and contribution of their staff and publicly said thank you through their 'caring at its best awards'. The award winners were staff who had demonstrated going the extra mile for colleagues and patients. There were six award categories, reflecting the trust values and aims to provide caring at its best. The five categories allowed staff to nominate colleagues for work and positive caring attitudes going beyond expectations. A sixth category allowed patients and public to nominate a member of staff who had touched their lives and provided the best care to them or their loved ones. Staff had been nominated as a result of initiatives they had been involved in for example, raising money through cake sales and tea party events to raise money to decorate retreat rooms.
- Ward F31 at GH won the "We do what we say we are going to do" winter 2015 award. They raised money from cake sales and knitting to buy a bladder scanner and patients' Christmas gifts. Staff told us helping the patients in this way really brought the team together.
- The thoracic team were also very proud to have been nominated for a 'caring at its best award' by a patient for excellent care. The Consultant, specialist nurses and all of the ward staff were very proud to have been selected.

Innovation, improvement and sustainability

- The overall aim for University Hospitals Leicester (UHL) was to make surgery safer at every step of the patient pathway. We were told this would include the World Health Organisation (WHO) safety checklist audit to

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achieve a 98% completion rate and identification of clinical champions (staff with a particular interest) to lead the 'safer surgery' message. Information provided from the trust after our inspection stated that the UHL safer surgery policy was currently being revised. The policy was in the planning stage with a timeline for implementation set for December 2016.

- The trust was committed to the development of advanced nurse practitioners (ANPs) to ensure patient care was enhanced and to mitigate the potential recruitment difficulties into junior doctor posts. Additional nurse training and education has enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate.

- The trust had remained committed to the band four advanced practitioner role, which offered development opportunities for healthcare assistants to expand their practice and work more independently with qualified nurses on the wards.
- Staff recruitment from Europe including Spain, Portugal, Italy and Greece, had significantly improved staffing levels.
- Glenfield Hospital hosts the UK Metastemolma Trust which is a charity that provides information and resources to patients and healthcare professionals.
- The Thoracic service had demonstrated excellent patient outcomes and was now a national mesothelioma centre. Mesothelioma is a cancer of the lining that covers most of the body's organs. It is usually caused by asbestos exposure.

Critical care

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

University Hospitals of Leicester NHS Trust (UHL) provides critical care services at Glenfield Hospital as part of the intensive care, theatres, anaesthetics, pain and sleep (ITAPS clinical management group). Critical care is delivered in a 22 bedded unit that is divided into three distinct bays (A, B and C). The critical care unit uses its capacity flexibly to care for both level two and level three patients as defined by the Intensive Care Society. Level two patients are those requiring more detailed observation and intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multi-organ failure. The critical care unit also hosted one of the world's busiest extra corporeal membrane oxygenation (ECMO) centres. Glenfield Hospital is the only hospital in the United Kingdom (UK) to provide ECMO therapy for both adults and children, with children being cared for in the paediatric intensive care unit (PICU). ECMO is used when a patient has a critical condition which prevents the lungs or heart from working normally. The ECMO machine is very similar to heart and lung machines used during open-heart surgery. It is a supportive measure that uses an artificial lung (the membrane) to oxygenate the blood outside the body (extracorporeal).

The critical care service at Glenfield Hospital admits around 1500 patients per year and is an active member of the Central England Critical Care Network as well as being registered with the extracorporeal life support organisation (ELSO).

A review of critical care would normally encompass any level two patient areas that lie outside of the intensive care unit. Throughout the trust there are a number of 'high dependency' or 'high care' areas that manage patients with a higher acuity than those normally found on a ward. In Glenfield Hospital there were such areas caring for patients with respiratory conditions, coronary care and following thoracic and cardiac surgery. The acuity of the patients within these areas was determined using the critical care minimum data set criteria and the staffing allocated accordingly. The care in these areas was not led by intensivists and they were not subject to the management and governance processes of critical care. They were managed by their respective speciality and consequently have not been included in the critical care core service report.

As part of the inspection we spoke with relatives and staff of all grades including nurses, doctors, consultants and allied healthcare professionals. We also looked at policies, medical records, procedures, performance and quality data.

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Summary of findings

We have rated critical care services at Glenfield Hospital as good overall because:

- There were sufficient numbers of suitably qualified staff to care for patients.
- We found a culture where incident reporting was encouraged and understood by staff.
- There was strong clinical and managerial leadership at both unit and management group level. The service had a vision and strategy for the future.
- There was an effective governance structure in place which ensured that the risks to the service were known, recorded and discussed. The framework also enabled the dissemination of shared learning and service improvements.
- Patients and their relatives were cared for in a supportive and sympathetic manner and were also treated with dignity and respect.

However we found:

- There were some issues with access and flow. In 2015, 21 patients had their elective surgery cancelled.
- Pharmacy provision for the critical care service did not fully meet the D16 service specification.
- There had been a recent never event involving medicines management and administration.
- The trust was not compliant with all aspects of NICE guidance 83 'Rehabilitation after Critical Illness'
- The critical care unit did not achieve the intensive care core standard (ICS) of 50% of staff having a post registration course in critical care, 29% of staff had completed this.

Are critical care services safe?

Good



We rated critical care services as good for safe.

We found:

- There were sufficient numbers of suitably skilled staff to care for patients.
- There were systems in place for reporting and learning from incidents and near misses.
- There was a robust approach to hand hygiene. Cleansing hand gels were available for all staff and visitors. We saw staff using hand gels and wearing personal protective equipment when delivering personal and clinical care.
- There were high incidents of harm free care.
- There were low incidents of unit acquired infections when compared with similar critical care units.
- There was an internal system for raising safeguarding concerns.
- The hospital used an early warning system for the early detection of deteriorating patients.

However we also found:

- Ongoing audits of infection control practices showed variable levels of compliance with the use of PPE and source isolation policies.
- Pharmacy provision for the critical care service did not fully meet the D16 service specification.

Incidents

- The hospital had a policy and electronic system for the reporting, management and investigation of incidents.
- Staff knew about the incident reporting system and were able to give examples of when they had used it. Staff also described how they learnt about incidents that had occurred within the trust. Incidents were discussed at shift handover as well as being presented at staff meetings.
- We saw that learning from a never event at another critical care unit at the trust was evident and that actions to avoid this happening again had been implemented on this unit. Never events are serious, wholly preventable incidents that should not occur if

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the available preventative measures had been implemented. A comprehensive investigation was currently underway using a root cause analysis (RCA) approach. In the meantime a series of immediate actions had been implemented, which included a change of practice, where red trays were being used to draw up controlled drugs with a double check being made by two nurses at the controlled drug cupboard.

- In the period March 2015 to March 2016, the data shared by the trust showed there had been 192 incidents reported from the critical care unit at Glenfield Hospital and one involving critical care outreach. These incidents included a range of events such as abusive and violent behaviour of patients, medication errors and infrastructure or resources failures.
- Of the total 193 reported incidents, one was reported as causing moderate harm, 40 caused minor harm with the remaining 152 reported as causing no harm or injury.
- Minuted monthly mortality and morbidity meetings were held during which incidents occurring since the last meeting were discussed.
- We asked staff about their understanding of the principles of 'duty of candour'. Staff responded by saying that it was their responsibility to be 'open and honest'. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person

Safety thermometer

- The NHS safety thermometer is a national improvement tool for monitoring, measuring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots or venous thromboembolism, was monitored on a monthly basis. The monthly safety thermometer results were displayed clearly at the entrance to the unit alongside a range of performance metrics.
- Safety thermometer results across the trust were published in an annual report. For the period April 2015 to March 2016 the numbers of acquired harms on the critical care unit was very low and for the last four months of the report demonstrated 100% harm free care.

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean and tidy.
- The trust had infection control policies and procedures in place, which were easily accessible for all staff.
- As part of the inspection we observed staff washing their hands appropriately, using cleansing hand gels and wearing personal protective equipment (PPE) such as aprons, gloves and masks. We saw staff adhering to the 'bare below the elbows' policy when in clinical areas.
- We saw the results of a trust wide hand hygiene audit carried out in November 2015. This showed that the average level of compliance with hand hygiene practice was 63%, this was an 8% improvement since the previous audit had been carried out. There had also been an audit across the trust of standard infection prevention and control measures and adherence to Meticillin resistant *Staphylococcus aureus* (MRSA) policies. The results were reported per clinical management group and broken down by staff group. For ITAPS overall there had been an 8% reduction to 79% in compliance with the use of PPE from quarter 2 to quarter 4. There had been a 12% reduction to 78% in compliance with source isolation policy and 26% reduction to 49% with MRSA policy compliance. Sharps safety was reported as being up 7% to 93%. MRSA is a type of bacterial infection and is resistant to many antibiotics.
- More specifically for the critical care service at Glenfield Hospital, the most recently validated the Intensive Care National Audit and Research Centre (ICNARC) data supplied by the trust for July to September 2015 showed very low numbers of unit acquired infections when compared with similar units.
- During the inspection, one of the critical care bays was being deep cleaned. We were told that each of the three bays (A, B and C) were deep cleaned in turn once every quarter. This practice had started in 2006 following an outbreak of *Clostridium Difficile* (*C. difficile*). *C. difficile* is a bacteria affecting the digestive system; it often affects people who have been given antibiotics.

Environment and equipment

- The critical care unit was divided into three distinct bays. Bay A had 11 beds, including three side rooms. One of the side rooms was equipped with a gowning and handwashing space. It also provided a variable air

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pressure and flow to facilitate both source and protective isolation. Bay B held five beds and Bay C six beds. Bay C also provided two side rooms, one of which had a gowning and handwashing lobby. Source isolation is the physical separation of one patient from another, in order to prevent the spread of infection. Protective isolation is the physical separation of a patient who may have a low immune system and be prone to infections.

- All bed spaces were equipped with the equipment required to care for a critically ill patient.
- We saw that resuscitation equipment; including defibrillators and airway management trolleys and drugs were available. According to the records all were checked daily.
- We saw a purpose built transfer trolley and associated equipment which was checked on a daily basis.
- Adjoining the critical care unit was a medical electronics area where the unit held its 'pump library'. All the infusion pumps were maintained with records kept of their maintenance history on a database. Any pumps requiring repairs were sent to Leicester Royal Infirmary. The technicians on each unit provided technical and educational support to the nursing and medical staff including dealing with technical problems at the patients' bedside, routine maintenance, calibration and quality assurance of equipment. For example, the technicians were supporting staff with the introduction of new arterial blood gas machines.

Medicines

- Trust medicines policies were regularly reviewed and were readily accessible to all staff through the trust's intranet.
- All drug cupboards were appropriately locked and the keys were kept securely in a nearby locked cupboard. The controlled drug keys were kept on the person of the nurse in charge of the shift.
- Controlled drugs were checked once a shift and following a recent dispensing issue, the stock check included checking all controlled drug boxes, even those that had not yet previously been opened. Controlled drugs are prescription medicines which are controlled under the misuse of drugs legislation e.g. morphine and pethidine.
- Staff and patients had access to a critical care pharmacist although the pharmacy service to the unit

did not fully meet with the D16 service specification. D16 is the NHS standard service specification for adult critical care. This was because there were delays in the supply and pharmacy advice and reduced attendance on the multi-disciplinary ward rounds. Clinical pharmacy attendance at multi-disciplinary ward rounds increases the effectiveness of the service as recommended in the Intensive Care Society standards.

- There had been a recent never event involving the management and administration of medicines, though not on the Glenfield Hospital site. As a consequence red trays had been introduced for the reconstitution and administration of controlled drugs. Staff on the unit knew about the incident and had been instructed in the changes to practice which had been subsequently introduced.
- There were 54 reported incidents relating to medicines in critical care at Glenfield Hospital between March 2015 and March 2016. These predominantly related to administration errors.
- As part of our record checks we looked at two prescription sheets. They were accurately completed and included details of any allergies.
- Records indicated that drug fridge temperatures were monitored and recorded daily, though we did note the occasional missed record. The drug room temperature was also being monitored and was recorded as being consistently 'high' this was raised with staff at the time of the visit. Action was taken at the time of the visit to address deficiencies in monitoring (and confirmed in place on unannounced visit.)

Records

- The critical care paper records comprised a range of clinical assessments, records and plans. These included for example; nutritional risk falls assessment, capacity assessments, pain scores and various evidence based care bundles. A care bundle is a structured way of improving patient care and outcomes based on a number of evidence based steps.
- Although entries in the records were usually signed and dated, the author's name was not always printed alongside their signature.
- Physiological parameters were recorded by the nurse looking after the patient on a large chart located by the bed space. This brought together all the patient monitoring and observations onto one chart so that

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ventilator (a machine that supports patients breathing) settings, fluid balance and vital signs such as blood pressure and heart rate could all be reviewed in one place.

Safeguarding

- There were trust wide safeguarding policies and procedures in place, which were readily available on the trust's intranet site.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse and neglect.
- Safeguarding training formed part of the trust's mandatory training programme. A safeguarding assurance paper from May 2016 reported that the compliance with safeguarding training across the ITAPS clinical management group was 96% for adult safeguarding and 92% for children's safeguarding.

Mandatory training

- A mandatory training record was held for all staff. Nursing staff within the unit were divided into teams and the team leader, usually a band 6 or 7 would encourage all their team members to keep up to date with their mandatory training programme. Individual nurses were contacted by email to remind them of mandatory training due dates.
- Mandatory training included moving and handling, infection prevention, fire safety, equality and diversity, information governance, conflict resolution and safeguarding adults and children. Training figures for September 2016 showed 93% of staff were in date with mandatory training.
- There was a unit based clinical nurse educator who was funded for 0.8 whole time equivalents (WTE). The Intensive Care Society standards suggest that there should be 1 WTE per 75 staff, responsible for coordinating the education, training and continuing professional development framework for critical care staff and pre-registration students.

Assessing and responding to patient risk

- The hospital had introduced a range of initiatives to improve patient safety. These had been developed following a review of incidents and focused on five key areas of practice. These were known as the 'five critical safety actions'. They were;

- Improving clinical handovers
 - Acting upon results
 - Attention to early warning systems and triggers
 - Senior clinical review
 - Implementation and embedding of mortality and morbidity reviews
- There was a critical care outreach service available 24 hours per day seven days per week comprising nurses with critical care experience who worked closely with the unit. The outreach nurses attended the handovers at each end of the day to keep apprised of patients on the unit who may be ready to step down to the ward. They were also able to contribute information about any deteriorating patients on the wards who may require critical care input or admission.
 - The critical care outreach staff were part of the cardiac arrest response team.

Nursing staffing

- The critical care matron kept an overview of the nursing establishment for critical care.
- The staffing establishment was calculated using the intensive care society guidance 'Levels of Critical care for Adult patients'. So this meant that one trained nurse would usually look after one or two level 2 patients with level 3 patients being looked after on a one to one basis. For patients receiving ECMO there was often the need for two nurses to be assigned that patient.
- At the time of inspection, there were adequate and appropriate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment.
- There was a supernumerary shift co-ordinator on duty each shift plus an additional band 7 nurse on a management day, who could be called upon if needed. Alongside the performance metrics there was also an up to date display of the planned versus actual staffing numbers on duty.
- The nursing establishment was divided into teams usually led by a band 7 and would comprise a mix of band 5 and 6 nurses plus health care assistants. Staff reported that they felt supported by the team framework.
- There were 8.9 WTE registered nurse vacancies and 0.7 WTE health care assistant vacancies at the time of the inspection visit.

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- It was a common occurrence for nurses to move across all three trusts critical care units to cover staff shortages. During the inspection two nurses went from the unit at Glenfield to help out the unit at Leicester Royal Infirmary.
- Recruitment and retention was an issue and the trust was currently revising and reviewing its recruitment processes. There had in the past been a recruitment drive for international nurses for critical care, which was reported as being successful.
- The unit used electronic nurse rostering and also used a 'closed' Facebook page for staff where they could negotiate shift changes or swaps. We were told this worked well. There was internal rotation of nurses between days and nights and the day shift was 07.30am until 8pm.
- Very little agency staff were used and when they were it tended to be agency nursing staff that had been to the unit before and whose competencies were understood.
- There was a handover at the end of each shift which involved all the incoming team. At this handover, important messages were shared such as incidents and changes to practice. After the general group handover, a bedside handover took place between the relevant outgoing and incoming nursing staff.

Medical staffing

- ITAPS had a designated clinical director and the critical care unit at Glenfield Hospital also had a designated clinical lead.
- We were told that there was currently one consultant vacancy, which meant that the on call rota for general critical care was one in nine and for ECMO was one in five.
- There were two consultant intensivists on duty from 8am with additional consultant cover on call for ECMO and patient transfers. Support was provided by registrar and airway trained medical staff throughout the day and night.
- When assigned to critical care, consultants had no other clinical responsibilities within the hospital.
- The unit also used advanced critical care practitioners to support the medical team.
- A structured medical handover took place at the beginning of each shift, this usually included attendance by a member of the outreach team.

- We attended a consultant led post ward round briefing that reviewed all the patients on the unit so that all the team were clear about care and treatment plans.
- The trainees we spoke with said there was a good balance between work and teaching.

Major incident awareness and training

- Critical care services had detailed plans for responding to the increased demands that a major incident would make on the service, while continuing to provide care for existing patients. The plans took account of national legislation and guidance such as the Civil Contingencies Act (2004) and the NHS Emergency Planning Guidance (2005).
- There was a major incident policy in place which was accessible on the trust intranet.
- Staff could not recall having had any specific training on the management of a major incident though knew where to find the action cards, should the major incident policy be activated.

Are critical care services effective?

Good



We rated critical care services as good for effective.

We found:

- There was evidence that evidence based best practice guidance was being used to determine care.
- Pain was being managed in accordance with UK pain management core standards.
- There was evidence based guidance in place for initiating enteral nutrition for patients.
- The use of band six nurses as clinical skills supervisors was working well to support staff in the clinical setting.
- Intensive Care National Audit and Research Centre (ICNARC) data reported that patient outcomes were comparable with similar critical care units.
- We saw evidence of both multi-disciplinary and seven day working.
- The assessment of mental capacity and associated deprivation of liberty safeguards (DoLs) was being managed in accordance with trust policy.

However we also found,;

Critical care

- The trust was not compliant with all aspects of National Institute for Health and Care Excellence (NICE) guidance 83 'Rehabilitation after Critical Illness'.
- Only 29% of registered nurses had completed a post registration course in critical care. The critical care unit did not achieve the intensive care core standard (ICS) of 50% of staff having a post registration course in critical care, 29% of staff had completed this.

Evidence-based care and treatment

- The critical care service used a combination of national and best practice guidance to determine the care they delivered. This included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible through the trust-wide intranet.
- The unit was not compliant with all aspects of NICE guidance 83, 'Rehabilitation after Critical Illness'. The trusts own audit against D16 service specifications for adult critical care reported in 2014 that none of the trust's three critical care units were compliant with the standard that states 'each patient must have an assessment of their rehabilitation needs within 24 hours of admission to critical care and all NICE 83 eligible patients must have a rehabilitation prescription on discharge from critical care.' The actions stated in the review document were to establish a service level agreement (SLA) for allied health professionals. It was not known if the required SLA had yet been implemented. A service level agreement (SLA) is a contract between a service provider (either internal or external) and the end user that defines the level of service expected from the service provider
- We saw there was participation in local audit and benchmarking. Results were collated in a scorecard format and presented and discussed at monthly meetings.
- Examples of the audits being undertaken were hand hygiene audits, showing compliance between 76% and 90% since April 2016. Malnutrition Universal Screening Tool (MUST) assessment audits and audit of high impact interventions (HIIs). HIIs are an evidence-based approach that relate to key clinical procedures such as catheter care or care processes that can reduce the risk of infection We also saw examples of action plans

developed to address poor areas on non-compliance. For example, actions to improve the hand hygiene audit compliance included training and re-education of staff on the importance of adhering to the five moments model for hand hygiene as well as trust policy.

Pain relief

- In accordance with the Core Standards for Pain Management Services in the UK, developed by the Faculty of Pain Management of the Royal College of Anaesthetists with input from CQC, acute pain management was supervised by consultants and specialist nurses with the appropriate training and competencies.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff also utilised a paper based pain scoring tool.
- The pain management team gave support and advice to staff and patients in critical care in relation to the management complex pain as well as the management of epidurals and patient controlled analgesia (PCA).
- We noted that the pain management team was represented at critical care team meetings.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately in the patient notes we reviewed.
- We saw records that showed strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.

Patient outcomes

- The critical care unit provided continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant that the care delivered and mortality outcomes for patients were benchmarked against similar units nationally. The most recently validated ICNARC data, for the period April to December 2015, showed a risk adjusted acute hospital mortality of 0.93, which was comparable with similar units and slightly better when compared with all units.

Critical care

- In the period July to December 2015, ICNARC data for the critical care unit at Glenfield Hospital showed that over 77% of admissions were from planned surgery with the majority being level three patients, at least for the first 24 hours of their stay.
- For ventilated admissions (patients receiving support with their breathing through a special machine), the mean length of stay was less than four days and the incidence of unit acquired infections in blood was zero.
- For patients admitted with severe sepsis the length of stay was comparable with similar units at around 10 days. **Sepsis** is a potentially life-threatening infection in the blood triggered by an infection or injury.
- For elective cardiothoracic surgical admissions the mean length of stay was about two and a half days which was comparable with similar units and the number of unit acquired infections in blood was zero.
- For elective coronary artery bypass grafts (CABG) the mean length of stay was just under two days with the unit acquired infection rate in blood was zero. A coronary artery bypass graft (CABG) is a surgical procedure used to treat coronary heart disease, It diverts blood around narrowed or clogged parts of the major arteries to improve blood flow and oxygen supply to the heart.
- For elective heart valve repairs, the mean length of stay had just crept above the rate for similar units at three days but was still within expected limits.
- For emergency cardiothoracic surgical admissions the mean length of stay was comparable to similar units and the acquired infection rate was zero. Cardiothoracic surgery is the field of medicine involved in surgical treatment of organs inside the thorax (the chest)—generally treatment of conditions of the heart (heart disease) and lungs (lung disease).
- The latest ICNARC data also showed that for early, late readmissions and post-unit discharge deaths the unit was performing better than similar units. Early readmissions are classified as unit survivors that are subsequently readmitted to the critical care unit within 48 hours of their discharge. Post unit deaths are classified as unit survivors that die before ultimate hospitals discharge.
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and this has been

shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress. This is considered good practice.

Competent staff

- Staff were appropriately trained, competent and familiar with the use of critical care equipment. Support was given to staff on site by the medical equipment technical team as required.
- The critical care unit at Glenfield Hospital had 0.8 WTE practice based educator. This falls short of the intensive care society standard for practice based educators for a unit of this size.
- There were six band 6 nurses who all had additional responsibilities as clinical skills supervisors. This gave them a formal educational role within the team for seven hours each week, where they each led on a specific area.
- The percentage of trained nurses who had undertaken a post registration qualification in critical care was around 30%. The expected standard is no less than 50%. There were plans for additional staff to undertake this specific training during the next intake. The department had doubled the number of staff supported in undertaking the critical care modules this year in order to meet the standard outlined. Going forward this number of nurses needed to support will be reviewed each intake to sustain the 50%. This needed to be balanced against funding and ability to support study leave. Critical care delivered an in house training program for staff to ensure staff are developed and competent.
- When agency nurses were used, the unit tried to obtain nurses who had regularly worked on the unit to provide some consistency. Agency staff had their competencies assessed before they worked unsupervised.
- Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- At the time of the inspection, 98% of nursing staff had received their annual appraisal.

Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place every day in critical care. Although not all members of the multi-disciplinary team were able to physically be there for the formal round, they did attend the unit at some point.

Critical care

- Care of the patients on the unit was intensivist led but multi-disciplinary in its approach to care. An intensivist, also known as a critical care physician, is a medical doctor with special training and experience in treating critically ill patients. There was effective communication between the nursing staff, medical / surgical teams and the intensivists.
- The effectiveness of the wider multi-disciplinary teams could be seen with referrals for ECMO therapy and the subsequent consultant led advice, assessment and retrieval of patients from their referring site, including mobile ECMO.
- There was evidence that medical and nursing staff worked together as a team for the benefit of patients. We saw minutes of multi-disciplinary meetings held regularly. We looked at copies of the mortality and morbidity meetings and saw that each death was reviewed and learning points were noted for dissemination.
- There was an outreach team available on site 24 hours per day seven days per week. They liaised closely with the critical care team in respect of patients due for potential step down as well as deteriorating patients on the wards.
- All staff had access to the information they needed to deliver effective care in a timely manner including test results, risk assessments and medical and nursing records.
- All the patient's physiological parameters, assessments, fluid balance and ventilator settings were recorded on a large critical care observation chart situated by the bedside.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information.
- The unit had a white board display which gave an overview of the current activity in the critical care unit. It showed the individual bed spaces and the acuity of the patients therein as well as the overall unit acuity or dependency. It also displayed staffing numbers per shift along with anticipated admissions and discharges or step downs.

Consent and Mental Capacity Act

- Staff demonstrated an understanding of the issues around consent and patients in critical care having the capacity to make their own decisions.
- There was a delirium policy and there were posters displayed on the corridor noticeboard which clearly highlighted the factors associated with delirium in a critical care setting.
- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient. Care plans stated that the CAM-ICU should be completed twice every shift. Examination of the patient records showed that this was carried out twice daily. The rationale being that delirium prolongs critical care and has long term sequelae. Early detection means earlier treatment. The CAM-ICU is an adaptation of the Confusion Assessment Method by Inouye (1990), the most widely used tool for diagnosing delirium by non-psychiatric clinicians. The CAM-ICU utilises yes/no questions for use with non-speaking mechanically ventilated patients.

Seven-day services

- A consultant intensivist was available seven days a week, including outside normal hours.
- The physiotherapy team provided a seven day service to the critical care unit during the day with an on call service out of hours.
- Dietetic, pain management, speech and language therapy (SALT), and pharmacy services were available Monday to Friday, 9am to 5pm. Pharmacy was open in the morning of Saturday and Sunday to provide a service to critical care if required. With the exception of dietetic and SALT all services were provided through an on-call system out of their opening times.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

Access to information

- Critical care notes were kept in a file by the patient's bedside.

Critical care

- There was one patient on the unit subject to a deprivation of liberty safeguard (DoLs) application. This had been made as a consequence of the patient's delirium and the application was being processed in accordance with trust policy.

Are critical care services caring?

Good



We rated critical care services as good for caring.

We found:

- Critical care services were delivered by caring, compassionate and committed staff.
- We saw patients, their relatives and friends being treated with dignity and respect.
- Staff demonstrated that they understood the impact of critical care on people and their families both socially and emotionally.
- We saw examples of staff 'going the extra mile' for relatives and friends.
- It was clear from talking to staff that they cared for their patients as individuals.

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit, and those close to them, in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitudes.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Privacy curtains were drawn around people with relevant explanations given prior to care being delivered.
- We spoke with relatives who were universal in their praise for the unit nursing and medical staff. They told us that they had been kept informed of everything that was going on with their relative.
- Friends and family test results were displayed on the noticeboard at the entrance to the unit and reported 100% satisfaction. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are

happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so that, where possible, they understood their care and treatment.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- The unit had been using patient diaries. These were usually started after three days in critical care and consent was obtained for their use. Intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, friends and family and can include photographs. Research has shown that patient diaries often help the individual better understand and make sense of their time in critical care and help to prevent anxiety, depression and post-traumatic stress. The critical care team were working with occupational therapists to develop the best way to share the diaries back with patients once they had been discharged.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families.
- There was a senior nurse for organ donation in post who worked closely with the unit staff in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- Bereavement services were offered to families and they were invited back to the hospital for a 'day to remember' event. Where there was an opportunity to talk to other families and relatives. They released memorial balloons and also had an opportunity to revisit the critical care unit should they wish to.
- There were dozens of thank you cards displayed on the unit, which showed the high regard that the staff were held in by the patients and their families that spent time on the critical care unit.

Critical care

Are critical care services responsive?

Good



We rated critical care services as good for responsive.

We found:

- There were plans to develop the service to reflect the needs of the local population.
- The unit had facilities to accommodate patients' relatives and friends.
- Patients were admitted to critical within four hours of the decision being made to admit.
- Low numbers of patients experienced a delayed discharge.
- Very few patients experienced an out of hours discharge.

Service planning and delivery to meet the needs of local people

- The future plans for the critical care service at Glenfield Hospital were set out in detailed business plans, which were tied into the reconfiguration of services across the trust. This ultimately would lead to an increase in critical care capacity on the Glenfield Hospital site. However, there was currently no capital available to take the plans forward.
- There were trust wide bed management meetings held throughout the day to monitor and review the flow of patients through the three hospital sites and this included the availability of critical care beds.
- There were facilities for relatives to wait or stay on the unit if they wanted to. The facilities included a 'quiet room' where private discussions took place between the critical care staff, friends and family.
- The unit had access to overnight facilities should it be necessary for a patient's family to stay close by.
- There was a nurse led critical care outreach service. This was provided 24/7 on the Glenfield Hospital site. The team comprised experienced critical care nurses at bands 6 and 7. There were no formal follow up clinics being held at present for ex patients though staff had been undertaking follow up clinics in their own time.

Meeting people's individual needs

- Care plans demonstrated that patient's individual needs were taken into consideration when planning and delivering care and treatment.
- Interpreting services were available within the hospital if required. There was a range of patient information leaflets explaining aspects of critical care. Staff knew how to access copies in an accessible format for people living with dementia or learning disabilities and in braille for patients and relatives who had a visual impairment. The leaflets were also available in a range of languages.
- Each of the bed spaces had a white board at the head of the bed which displayed a welcome message and personal information about the patient including 'name', 'I like to be called...' and 'likes and dislikes'. In addition, there was a laminated bed book giving information about the unit.

Access and flow

- The unit collected data locally about occupancy and patient flow and also contributed data to the intensive care national audit and research centre (ICNARC). ICNARC then published a validated quarterly report where the unit at Glenfield Hospital was compared with similar units nationally.
- Looking at the local data for 2015 (January to December). The critical care unit at Glenfield Hospital had 1569 admissions with occupancy varying between a high of 108% in February 2015 through to a low of 71% occupancy in May 2015. The largest percentage of admissions comprised patients whose admission was planned following elective or scheduled surgery.
- Of the 1569 admissions, local data showed that 26 (1.7%) experienced a delay in their discharge greater than 24 hours.
- The local data for 2015 also showed that there were 21 cancelled electives for the period.
- The most recently validated ICNARC data for the period April to December 2015 shows a delayed discharge rate of 1.3% when considering bed days of care for delayed discharges divided by the total number of bed days available.
- The ICNARC data also shows for the same period that only two patients (very small numbers below one percent experienced an out of hours discharge. This performance was better than similar units (0.6%) and all units (2.2%).

Critical care

- For non-clinical transfers out in the same period, the unit performed within the expected range for similar units at two patients (0.2%).

Learning from complaints and concerns

- The hospital had clear policies and procedures to follow in the event of a complaint being made.
- The trust website detailed information for people about how to raise a complaint. Help and support was available via the trust's patient information and liaison service (PILS).
- The trust held an independent complaints review panel in conjunction with local Healthwatch and POhWER. The panel was established to review a sample of patient complaints and review them from the patient perspective. POhWER is a charity and membership organisation that provides information, advice, support and advocacy services for people who have a disability or who are vulnerable.
- Senior staff told us that the unit received very few complaints. A list of all formal complaints received by the trust between March 2015 to March 2016 showed there had been no formal complaints raised regarding the critical care unit at Glenfield Hospital.

Are critical care services well-led?

Good



We rated critical care services as good for well-led.

We found:

- There was a clear vision and strategy for the critical care service at Glenfield Hospital.
- There was an effective governance structure in place which ensured that risks were captured and discussed.
- There was strong clinical and managerial leadership at both unit and management group levels.
- The critical care service engaged with its staff and patients to inform the improvement and development of its delivery.

However we also found:

- Plans for reconfiguring and developing the capacity of the critical care service were on hold due to financial constraints.

Vision and strategy for this service

- The trust had commissioned an external review of its critical care service which reported the trust was under resourced for both level 2 and level 3 beds. The trust's five year plan for the Glenfield Hospital site would also see the satellite 'High Dependency Unit' (HDU) ward based areas being absorbed into the critical care service and so coming under the management and governance of critical care.
- There was a detailed business plan for the development and reconfiguration of critical care services across the trust. These included the expansion of critical care beds on the Glenfield site, with the addition of a further 11 beds, to accommodate the increased need for capacity as other services also reconfigured and relocated.
- An increase in the critical care beds at Glenfield Hospital would see the following benefits; increased capacity and facilities meeting current core standards, maximise the efficiency of patient flow between level 2 and 3, minimise cancellation on the day of surgery, improve capability to meet cancer waiting time targets, provide opportunities to improve recruitment and retention and create a better environment for training clinicians.
- The trust's critical care service was subject to ongoing development alongside a reconfiguration of services across the three trust sites. For the Glenfield site this meant physically extending the unit. Owing to financial pressures, these development plans were currently on hold.

Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- Critical care risks were recorded on an ITAPS risk register. We saw a risk register report dated 31 March 2016. It detailed six risks assigned to critical care. Four of the risks were reported as affecting all three critical care units and related to bed capacity, lack of clinical support services, recruitment to consultant vacancies

Critical care

and access and flow. For each risk on the register there were details of the issues alongside existing controls in place to mitigate the risk. The register included review dates.

- A range of meetings were held regularly, including mortality and morbidity meetings, staff meetings for all grades and ITAPS quality and safety board meetings.
- There was an acknowledgement and understanding of the access and flow pressures in critical care. Senior staff worked daily in collaboration with peers across the hospital and the wider trust to monitor, anticipate and try to alleviate the associated patient flow pressures through the critical care units.
- The unit was a member of the Central England Critical Care Network. We did not see a copy of any network review of the critical care service but we did see the results of a benchmarking exercise, where the unit was measured against the D16 Service Specification for adult critical care. The copy of the review we saw was not dated.
- Sickness and absence rates were closely monitored alongside the management of competency and capability. The sickness rate was 4.85%, for July 2016, against a target of 3%.

Leadership of service

- The critical care unit had designated consultant and nurse matron clinical leads.
- The critical care unit was led and staffed by a team of experienced nurses.
- There was a clear and strong leadership at unit and management group level with staff who had the skills, integrity, capacity and capability to lead the service effectively. Senior staff were visible in the critical care unit, leading and supporting their teams.

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care.
- Staff were encouraged to report incidents and raise concerns.
- Staff told us how supported they felt by the team approach to managing the critical care unit.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.

- There was an understanding amongst staff of the implications of duty of candour and we were given examples of where shortfalls in patient experience or care had been shared with relatives in accordance with duty of candour principles.

Public engagement

- The trust website included details about the critical care service at Glenfield Hospital.
- Whilst the unit did display information about visiting times, we heard from both staff and relatives that visiting was at the discretion of the nurse in charge and exceptions were often made to allow relative's to visit their loved ones.
- The trust produced a range of publications for the population it served. These included an annual quality account and an updated five-year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, the trust ran a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions are being carried out to try and avoid cancelling operations.
- The critical care service trust had adopted the use of 'Patient Partners'. Patient partners are members of the public who provided a patients' or 'lay' perspective on the experience of being cared for at the University of Leicester Hospitals. They get involved in a wide range of issues from changes to services through to advising on new developments and reviewing literature.

Staff engagement

- Staff reported that they were well supported and had access to training opportunities.
- The trust produced a regular newsletter called 'Together', in which the chief executive introduced a range of news and interest stories from across the organisation. This was used as one way of keeping staff engaged and informed about service developments.
- We saw minutes from a range of staff meetings held within critical care that gave an opportunity to share important messages and also update staff groups about critical care developments.

Innovation, improvement and sustainability

Critical care

- The trust has recognised that in order to meet the needs of its population and to develop its critical care services in line with strategic objectives, the service needed to be reconfigured. This was on hold due to the trust overall financial pressures.

Services for children and young people

Safe	Good	
Effective	Outstanding	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Children's services at the University Hospitals of Leicester NHS Trust are based at the Leicester Royal Infirmary (LRI), Leicester General (LGH) and Glenfield (GH) Hospitals. The GH has one paediatric ward with 12 beds, a paediatric outpatients department and a paediatric intensive care unit (PICU) with 7 beds, including two beds providing extracorporeal membrane oxygenation (ECMO) care. ECMO is used when a patient has a critical condition which prevents the lungs or heart from working normally. The ECMO machine is very similar to heart and lung machines used during open-heart surgery. It is a supportive measure that uses an artificial lung (the membrane) to oxygenate the blood outside the body (extracorporeal).

Between September 2014 and August 2015 the trust recorded 848 paediatric episodes of care for children and young people, of which 21% were classified as emergency, 69% elective and 10% day case at the GH.

The East Midlands Congenital Heart Centre is based at the GH, caring for patients with congenital heart disease from before birth to adulthood. Services provided are the internationally recognised ECMO unit, 24 hours a day seven days a week retrieval service, experienced cardiac team and the ability to see patients close to where they live, through the East Midlands outreach service.

The children's service at the GH comprises of three clinical areas. During our inspection of children's and young

people's services at the GH, we visited PICU including the ECMO service, the children's outpatients departments, theatres and an inpatient children's and young people's ward.

During our inspection, we spoke with eight patients and 11 parents or relatives. We spoke with 20 staff members including medical, nursing, allied health professionals, and administrative staff. We checked 19 pieces of equipment including resuscitation equipment.

We observed care and treatment and looked at four patient records and two staff records. We reviewed information provided by the trust before, during and after the inspection.

Services for children and young people

Summary of findings

Overall we rated the children's and young people's service as good because:

- There was a positive incident reporting culture. Staff knew how to report incidents and gave examples of when they had done so. There was appropriate incident investigation with actions and learning shared amongst staff.
- Staff adhered to trust infection prevention and control policies and we saw staff using hand sanitiser between patient contacts. All equipment including resuscitation equipment had been tested and checked regularly.
- We observed positive, compassionate care and staff were sensitive to the needs of babies, children, young people and those close to them. Without exception, patients and those close to them were positive about their care and treatment. Patients felt involved in their care and treatment. Staff communicated in ways, which enabled patients and those close to them to understand what was happening.
- The hospital provided specialist services for patients, including the Congenital Heart Centre and extracorporeal membrane oxygenation (ECMO) care. Staff met patient's individual needs and could access specialist support such as interpretation, spiritual support and specialist nurses.
- Staff assessed and responded to pain appropriately therefore patients had timely access to pain relief. Staff had access to a children's pain team.
- Services for Children and Young people conducted audits to monitor patient outcomes. The results of these audits were the same as or exceeded England average outcomes.
- There was a clear vision and strategy for the service. There was a positive and open culture and staff were proud to work at the hospital. Leaders were visible and they engaged and listened to staff. We saw positive examples of innovation to improve services delivered.

However:

- We saw there were training shortfalls regarding the numbers of staff training in Advanced Paediatric Life

Support (APLS) and European Paediatric Life Support (EPLS). The service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance. Twenty eight out of 67 (42%) nursing staff were in date (the last four years).

- The service did not meet the trust target of 95% for all subjects covered under mandatory training for both medical and nursing staff.

Services for children and young people

Are services for children and young people safe?

Good



We rated safety in the children's and young people's service as good because:

- Staff knew how to report incidents and could give examples of when they had done so. The service investigated incidents according to trust policy and we saw examples of identified actions and learning shared amongst staff.
- We observed staff adhering to infection control policies, which included bare below the elbow, use of personal protective equipment and cleaning hands before and after patient contact.
- All equipment including resuscitation equipment, had been tested and checked daily.
- Escalation plans were available for the Children's Hospital, paediatric intensive care and the ECMO Unit.
- Staff conducted nursing handovers called 'safety huddles' to ensure all staff had up to date information about patients. Staff discussed new and existing patients, their medical history and care plans highlighting any key information including potential risks to patients.
- Medicines management was mainly in line with trust policy.

However, we found:

- Training shortfalls existed in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance.
- The service did not meet the trust target of 95% for all subjects covered under mandatory training for both medical and nursing staff.

Incidents

- An incident reporting policy was available for staff to refer to; it included the incident grading system and external and internal reporting requirements. Incidents were reported through the trust's electronic reporting system.

- There were no never events in this service between March 2015 and March 2016. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although a Never Event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- The trust reported no serious incidents between May 2015 and April 2016. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant they warrant using additional resources to mount a comprehensive response.
- At the time of our visit we saw 252 incidents had been reported at the Glenfield Hospital unit from March 2015 until March 2016. Each incident was categorised and identified the actions taken. Of these incidents, two were in the category of moderate harm, 50 in minor harm and the majority 200 in no harm or injury.
- Of the 252 incidents, eight were reported as near misses. A near miss is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so.
- The trust had systems in place to enable the reporting, investigation and the learning from incidents. Clinical governance, quality and safety meetings, and monthly trust board level meetings discussed incidents and significant events. The majority of staff received feedback on learning from incidents at weekly 'QUICKA' meetings, emails and through staff bulletins. Staff also used a communication book to pass on or catch up on learning from incidents. We saw learning from incidents highlighted on staff notice boards and in minutes of team meetings.
- We reviewed four serious incidents where a root cause analysis approach had been taken. Root cause analysis is an approach for identifying the underlying causes of why an incident occurred. We saw there had been full investigations, action plans and lessons learnt. One of these incidents had taken place from November 2015 to March 2016 within the children's hospital. We saw evidence of learning following this incident. The outcome had resulted in changes to processes, for example, all senior doctors on the paediatric intensive care unit (PICU) covering paediatric cardiology should have access to the computer system where information for cardiology patients was stored.

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- Clinical performance data was captured monthly from each clinical area and reported within the 'Children's Services Quality Dashboard.' Minutes of the 'Quality Safety and Governance group' (October, November 2015 and January 2016) confirmed discussion of ongoing performance and actions relating to dashboard data including mandatory training, safety issues and medication errors.
- The children's hospital had monthly mortality and morbidity review meetings. Mortality and morbidity meetings allow health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. We reviewed four sets of minutes (December 2015, January 2016, March 2016 and April 2016) which included lessons learnt, preventability and duty of candour implication. We also reviewed two mortality and morbidity meeting case presentations for the hospital (April 2016) which included evidence of treatment provided, outcomes and learning.
- All clinical staff demonstrated some knowledge about the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We saw examples of where staff applied the duty of candour appropriately. These incidents included a breach of patient confidentiality and where staff had performed a scan on the wrong patient, in these incidents an immediate apology had been given to the patient. Staff provided examples where they had been open and honest with patients, parents and carers regardless of the seriousness for example, medication errors.
- Meticillin sensitive Staphylococcus Aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between April 2015 and June 2016 there were no recorded cases of MSSA within the children and young people service.
- In order to measure compliance with trust policies, the Infection Prevention Team (IPT) carried out regular audits against key policies. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy. Data from the trust showed in March 2016 the women and children's directorate scored 89% compliance for PPE, 94% for sharps safety and 66% for adhering to the MRSA policy. These were measured against a trust target of 90% and reports produced by the trust showed where compliance was low the trust identified and implemented actions.
- Hand hygiene audits were undertaken to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
- Results for the December 2015 hand hygiene audit; (before patient contact and after patient contact) demonstrated 60% and 78% compliance respectively across 16 clinical areas within Women and Children's clinical management group. The results included both Glenfield Hospital and Leicester Royal Infirmary. This was better than the trusts overall compliance figures but worse than the trust target of 90%.
- We observed staff on all wards adhering to the trust "bare below the elbow" policy. Staff were observed using equipment provided to reduce the risk of infection such as gloves and aprons and washing their hands before attending to patients. We saw staff using hand sanitiser between patient contacts.
- Monthly infection and prevention environmental audits demonstrated a compliance rate of 88% (March 2016) on ward 30 and 92% (May 2016) on the paediatric intensive care unit (PICU). The auditor clearly documented feedback and actions.
- The PICU had two isolation rooms staff used to place patients who were at risk of infection. The rooms had an

Cleanliness, infection control and hygiene

- There were two cases of Clostridium Difficile (C. difficile) infections between April 2015 and April 2016 occurring in the children and young people service. C. difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between April 2015 and April 2016 there were no cases occurring in the children and young people service.

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air lock with two sets of doors to the room. Outside the room was dedicated infection control equipment and personal protective equipment (PPE) to prevent the spread of infection. We observed staff following trust policy of using PPE and ensuring the isolation rooms were secure.

- Staff labelled and assembled sharps boxes correctly and we saw they were below the maximum fill level.
- Nurses were responsible for daily checks to bed areas to ensure all equipment and beds were clean. We saw the checklists were fully completed and up to date.
- The hospital participated in the 2014 Care Quality Commission (CQC) Children and Young People's Survey. This is the first national children's survey conducted by CQC. It represents the experiences of nearly 19,000 children and young people who received inpatient or day case care in 137 acute NHS trusts in 2014. The trust scored eight (8.4) out of ten from parents and carers of children aged eight to fifteen for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

Environment and equipment

- All areas we visited were visibly clean and uncluttered which meant staff, patients and their relatives/carers could move around the ward safely. It also meant staff could access patient's bedside and equipment easily.
- There were secure card pass entries to the wards we visited with an intercom and camera system for visitors. This helped to prevent unauthorised persons from accessing ward areas, keeping patients safe.
- We checked 19 pieces of equipment and saw all equipment was seen to be in date for electrical testing and had been checked.
- All resuscitation equipment was found to be checked and in working order. There was a fully completed log of the checks for the resuscitation equipment. The nurse in charge had the responsibility to undertake daily checks and we saw these had been done.
- There were signs on the specialist equipment stating staff must not move the equipment and there were locks in place to prevent the equipment being tampered with. This means that in an emergency the equipment would be immediately ready for use.
- There were equipment checklists at each bed space on PICU, which staff completed in detail to ensure the

equipment was continually available for use. However, there was no check for the wall oxygen supply on the list. We raised this with one of the unit managers at the time of the inspection.

- In the 2014 Care Quality Commission (CQC) Children and Young People's Survey the trust scored 8.6 out of ten from parents and carers of children aged eight to fifteen for the question 'Did the ward where your child stay have appropriate equipment or adaptations for your child?' This was about the same as other trusts.
- Wards had dedicated milk fridges to ensure the safe storage of breast milk at the correct temperatures. One fridge which contained expressed breast milk also stored food items and was not locked. This meant it was not protected from tampering and anyone could gain access.
- The PICU had an extracorporeal membrane oxygenation (ECMO) machine. The ECMO machine is similar to the heart-lung bypass machine used for open-heart surgery. Therefore, ECMO is the use of an artificial lung (membrane) located outside the body, (extra corporeal) that puts oxygen into the blood (oxygenation) and continuously pumps this blood into and around the body. Glenfield Hospital is only one of three hospitals in the country to use this machine.

Medicines

- Medicines management was mainly in line with trust policy, for example, staff locked medicines in cupboards. Staff signed and dated drug charts and prescribed medicines in line with British National Formulary (BNF) and Royal College of Nursing (RCN) guidance.
- Staff stored intravenous (IV) fluids in boxes in locked storerooms. We checked IV fluids on the children's ward and saw they were all in date.
- Controlled drugs (CD) are medicines requiring additional security. We saw controlled drugs were stored, managed and recorded appropriately. We observed from records staff checked them regularly and the CD check records were complete. All drugs we checked were in date.
- Between June 2015 and May 2016 there were 59 medication errors reported 56 were 'no harm' and three were 'minor harm.'
- The trust had two paediatric pharmacists provided support to the PICU and the children's ward. Staff could access on-call pharmacists at weekends.

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- On admission, staff recorded children's height and weight to allow for accurate calculations regarding drug administration. This was in line with both BNF and RCN guidance.
- We saw staff identified and clearly recorded patient's allergies and any other conditions in patient records. As part of the theatre pathway staff checked these with the patient or those close to them prior to surgery to ensure there were no errors. This informed staff what medications they could prescribe patients.

Records

- We checked four patient records. All the records were fully complete and contained all necessary information. All records were easy to read and legible. We found consultants signed, dated, and initialled records in line with General Medical Council standards in all records we looked at.
- Care plans were up to date and we saw evidence in patient records staff reviewed them regularly. We saw risk assessments completed and where identified actions followed up and documented.
- Information relevant to keeping a child safe was recorded and available including other clinicians and members of the multi-disciplinary team caring for the patient. Any safeguarding information or questions asked by clinicians were recorded in patient's records including any contact with the local authority.
- The service had systems to flag records where a patient had particular needs, including child protection. There was a 'traffic light system' within the trust safeguarding children's policy designed to support staff to identify a process to follow to address the safeguarding needs of a child or young person. The system included 'red' for child protection, 'amber' for safeguarding concerns and early help and 'green' for information only.
- We reviewed four sets of patient records. We saw in one set of notes staff in the multidisciplinary team had not started discharge planning. This meant there was a risk the patient would not receive timely care and support by other professionals after leaving hospital. An audit of discharge planning in patient records showed in May 2016 found 63% of records contained discharge planning. Managers had identified this as an area for improvement within children and young people's services.
- The trust had a safeguarding children's policy (review due November 2018) which included child abduction (Appendix 19) and a current Safeguarding Supervision policy (review April 2019). The majority of staff we spoke with knew of the policy and could describe different types of abuse as stated under the policy.
- The trust had a safeguarding lead at executive level; in addition, there was a named paediatric consultant and local named leads for children and adult safeguarding. The majority of staff we spoke with knew who their local named leads were and all staff knew there was a dedicated safeguarding team they could contact.
- The number of children's safeguarding referrals or alerts received by the trusts safeguarding teams for 2015 was 7921; this was a significant increase in comparison to 5478 referred in 2014. In response to this there had been further investment to improve access to the specialist safeguarding teams and increased visibility within clinical areas.
- The National Institute for Health and Care Excellence (NICE) safeguarding guidance recommends qualified staff groups who directly care for children are trained to a level three standard in safeguarding. Staff attended level one and two child safeguarding training, initially at trust induction and then during annual mandatory training. The safeguarding team provided safeguarding training at level three. All levels of training included female genital mutilation (FGM) and child sexual exploitation (CSE).
- Staff guidance notes for the management of women who had undergone FGM, a flow chart and information links were available on the trust website. The trust also undertook mandatory reporting of FGM to the Home Office.
- Not all staff were trained and compliant with level three safeguarding training. Intercollegiate guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' published in March 2014 sets out non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers should be trained to level three in child safeguarding. The trust had a system where staff were allocated to receive the correct level for their area and role. The trust target was 95%. All staff we spoke with said they had received safeguarding training. Data from the trust as of July 2016 showed 72 out of 78 (92%) of nursing and 19 out of 28 (67.8%) of medical staff were compliant with level three safeguarding training.

Safeguarding

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- Data from the trust showed 11 (58%) out of 19 paediatric consultants working at the hospital were compliant with level three safeguarding training. Information provided by the trust stated there was always a consultant available trained to level three safeguarding to provide immediate support and subsequent assessment if necessary where there were child protection concerns.
- The trust followed the Local Safeguarding Children's Board (LSCB) core competency framework and the intercollegiate document Protecting Children and Young People: The responsibilities of all doctors, General Medical Council (2012). A joint safeguarding review group held a monthly meeting to discuss cases, experiences and learning.
- All named safeguarding leads received one-to-one safeguarding supervision however; matrons and designated safeguarding link staff provided safeguarding supervision for all other staff as required. The trust acknowledged they wanted to extend supervision opportunities and would be offering 12 members of staff places to undertake safeguarding supervision in September 2016.
- The trust followed the Local Safeguarding Children's Board (LSCB) policy related to CSE. Staff accessed guidance notes for the management of children suspected of suffering from CSE from the trust website. The trust was in the process of adding a list of children at risk of CSE to the main computer system with alert flags attached.
- The trust had nine serious case reviews (SCR) which were responded to through involvement and engagement with partner agencies. Shared learning and development of procedures included a neglect tool for launch in July 2016.
- In the 2014, the Care Quality Commission (CQC) Children and Young People's Survey scored the trust 9.42 out of 10 from parents and carers of children aged eight to fifteen for the question 'Did you feel your child was safe on the hospital ward?' This was about the same as other trusts. The survey scored the trust 9.81 out of 10 for the question 'Did you feel safe on the hospital ward?' which was better than other trusts.
- The trust confirmed there was no automatic system to identify children subject to a child protection plan and due to the volume of children using the service it was impractical to ring and check with social care for every attendance. The trust had signed a commitment to use the national Child Protection Information Sharing

Project (CP-ISP) once this was available in the region. CP-ISP connects local authority children's social care systems with those used by NHS unscheduled care settings. It enables the exchange of key child protection information and episodes of unscheduled NHS care.

- Staff could access procedure guidance for the 'unexpected death of a child' from the Leicester Safeguarding Children's Board website.
- The trust chaperone policy was available giving specific reference to children and young people. During our inspection staff told us they were aware of the policy. We saw signs displaying information regarding the role of the chaperone and how to request this if required.

Patient Safety Thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The trust collected data on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CAUTIs), and blood clots or venous thromboembolism (VTE). The trust report all Safety Thermometer data was under the heading 'mixed specialty' and as such specific data for children could not be extracted
- The children and young people's service used a monthly clinical measures dashboard, which collected scores from the wards for a number of measures including patient observations. A red, amber, yellow and white performance threshold of reporting was used by the trust; this indicated levels (zero to three) of concern. Red indicated most concern (level three) to white for no concern (level zero). For May 2016, the hospital paediatric wards scored 100% (white – level zero) compliance for patient observations. If there were concerns highlighted, the nurse in charge of the ward managed these and information passed to members of staff at handover meetings. If there were any wards of concern staff escalated these to the Chief Nurse. Managers presented the dashboard at the monthly Quality and Safety Performance review meetings.
- Results from June 2016 Central Venous Catheter (CVC) Audit showed children and young people services scoring 79% over all compliance with CVC practices.
- Avoidable pressure ulcers can develop if appropriate interventions were not in place. Grading for pressure ulcers is described as grade two for an abrasion, blister

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or shallow crater and grade three as full thickness skin loss. Data from the trust for April 2015 to April 2016 demonstrated four grade two and one grade three avoidable pressure ulcers. The trust does not have comparison data to other trusts for rates of pressure areas in children and young people.

Mandatory training

- The trust delivered a two day corporate induction for all new staff which included the organisation corporate vision and objectives, fire safety and basic life support. An additional day for local induction included counter fraud, dementia training and conflict resolution.
- The Children's and Young People's service also provided an eight day preceptorship programme for newly registered nurses working in the children's hospital, this included medicines, sick child day, pain study day and safe care and communication day. An action plan to assist the development of qualified nurses to record their progress and areas of development was in use. We spoke with two members of staff who told us they valued their preceptorship. We saw one completed and signed action plan.
- Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, safeguarding children (level one and two), conflict resolution, safeguarding adults (level one), health and safety, basic life support, consent and Mental Capacity Act 2005 (MCA) and deprivation of liberties safeguards (DoLs).
- The trust reported all mandatory training data to the clinical management group 'women's and children's' data for the children's service.
- Training statistics for the 2015 to 2016 training year demonstrated staff in the children and young people clinical management group were below the trust target of 95% for attendance of mandatory training. Data confirmed six subject areas out of 11 for qualified nursing staff which included information governance (85%), consent, MCA and DoLs (63%), fire safety (87%), moving and handling (94%), infection prevention (89%) and basic life support (91%).
- For medical staff in the children and young people clinical management group all 11 subject areas were below target which ranged from 44% consent, MCA and DoLs and 88% for equality and diversity and health and safety. For non-qualified nurses in the same clinical

management group six out of 11 subject areas included consent, MCA and DoLs (63%), basic life support (82%) and fire safety (85%). For allied health professionals seven out of 11 included consent, MCA and DoLs (39%), basic life support (73%) and information governance (81%).

- We spoke with 20 members of staff of all grades, and all confirmed they had received a range of mandatory training and training specific to their roles.

Assessing and responding to patient risk

- The Trust worked in partnership with another acute trust to establish a Paediatric Intensive Care Transport service alongside the Centre Newborn Transport service to ensure children are in the right hospital, at the right time, for the right care.
- The paediatric early warning score (PEWS) and the neonatal early warning score (NEWS) were additional tools used to monitor children and babies who may be at risk of deterioration to record routine physiological observations such as blood pressure, temperature, and heart rate. PEWS and NEWS were used to monitor patients and initiated calls to the medical staff when required.
- Patients with a suspected infection or a PEWS or NEWS of three or more, or those for whom staff or relatives had expressed concern were screened for sepsis, a severe infection which spreads in the bloodstream.
- Patients treated for sepsis were to be treated in line with the 'Sepsis Six Bundle', key immediate interventions increase survival from sepsis. There was strong evidence the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six Bundle prevents treatment that is much more extensive and shown to be associated with significant mortality reductions when applied within the first hour.
- During our inspection of this hospital, we reviewed four patient observation charts across four clinical areas. All charts we reviewed had full observations and pain scores completed and recorded. Nursing staff completed PEWS scores completed at each time of recording the patients' observations and calculated correctly. Staff recorded patient's intake and output on fluid balance charts.
- We noted one of the sepsis screening criteria on the sepsis proforma stated the proforma should be completed using agreed criteria. One of the criteria was if the capillary refill time was above three seconds, (the

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time taken for colour to return to an external blood vessel after the application of pressure). However, we could not see any prompting on the PEWS charts to remind staff to carry this out, therefore there was a potential risk some children may not get appropriate screening for sepsis should they meet the criteria.

- When a child or young person required surgery, staff took patients to the anaesthetic room prior to surgery. Surgical staff used two paediatric trained operating department practitioners (ODP); one to monitor the patient outputs via the monitors and another to monitor anaesthetic gas lines. This meant staff could identify and respond to any problems quickly.
- Staff transported patients straight to PICU after surgery. A recovery area was not needed because the PICU had all necessary equipment and trained staff to observe and monitor a post-surgical patient.
- Staff conducted nursing handovers called 'safety huddles' to ensure all staff had up to date information about patients. Staff discussed new and existing patients, their medical history and care plans highlighting any key information including potential risks to patients.
- Data provided by the trust demonstrated the hospital had a backlog of 1027 letters in paediatric cardiology starting from 5 May 2016. A statement provided by the trust stated they were working in partnership with an external provider to reduce the backlog over a 12 to 14 week period with priority focusing on the oldest waiting letters first. Weekly monitoring of progress against planned activity was on going. This was a new addition to the children's risk register as referenced in the Children's Hospital Quality, Safety and Governance meeting minutes (May 2016). We were not assured that clerical backlogs were not affecting children's safety by delays in referral and prompt treatment.

Nursing staffing

- Planned nursing staffing levels across the 3 clinical areas totalled 67.8 whole time equivalents (WTE). Data for March 2016 showed actual staffing levels to be 70.1 WTE giving a combined vacancy rate of 0%. Vacancies varied across clinical areas the highest vacancy rate for the hospital was in the paediatric intensive care unit (3.3 WTE).
- Reduced staffing capacity was recorded as an issue on the trust's Women and Children's clinical management group risk register. All of the staff we spoke with said

staffing levels were adequate, but sometimes tight. They said they had never felt levels had fallen so low that patients were unsafe. Staff we spoke with were aware of how to communicate and escalate staffing issues to their ward manager

- Senior nurses covered gaps in staffing by using agency and bank staff. The average nursing agency usage for April 2015 to March 2016 across the children and young people's service was noted to be between 0.1% and 5.4%. However, agency staff used in respiratory paediatric medicine significantly increased from September 2015 to March 2016 noted to be between 0.2% and 8.2% across the same reporting period.
- On inspection, we saw staffing levels complied with Paediatric Intensive Care Society g. For example, we saw 1:1 care for intensive care, 1:2 for high dependency and 1:4 for special care. On all wards, we saw there was a minimum ratio of 70:30 registered to unregistered staff.
- Data provided by the trust for the hospital paediatric intensive care and cardiology unit demonstrated, as of July 2016, 15 out of 46 (32%) and 13 out of 21 (62%) nursing staff respectively were currently in date (the last four years) for one day Paediatric Life Support training. This did not meet the trust target of 95% compliance.
- The Paediatric Intensive Care Unit had some members of staff previously trained in APLS but required their three yearly update. A total of ten staff were currently up-to-date with their APLS competencies. Staffing rotas for a four week period between May and June 2016 for the PICU at the hospital demonstrated a member of staff trained to APLS competence covered 84% of day and night shifts. This did not comply with the Royal College of Nursing (RCN) 2013 standard.
- The trust identified they did not have one nurse per shift with either the 'Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training.' The trust highlighted none of the ward or high dependency areas currently have up-to-date APLS competence. However, this did not comply with the Royal College of Nursing (RCN) 2013 standard of having at least one nurse per shift in each clinical area to be trained in APLS or EPLS. We could not be confident staff could provide safe care and treatment for service users in an emergency.
- The children's service prioritised the provision of access to courses for intensive care unit staff but recognised high dependency areas and the Children's Admission

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Unit (CAU) were also high priority areas. Due to limitations of education funding the service were exploring different ways of funding to meet the current need.

- The trust confirmed staff received training on 'recognising the sick child' as part of their basic life support training which was incorporated in the mandatory training. A statement provided by the trust commented mandatory training was delivered for clinical staff but all of the mandatory sessions could be obtained separately from the corporate teams, therefore non-attendance does not indicate non-compliance.

Medical staffing

- The children's service confirmed they were compliant against the Royal College of Paediatrics and Child Health (RCPCH) and the BAPM consultant staffing standards and guidelines.
- Information provided by the trust showed the service had a total of 112 WTE medical staff, 35 (31%) of the 112 were consultants which was in line with the England average and 17 (15%) of the 112 were Junior doctors which was a larger proportion than the England average.
- The average medical agency locum usage for April 2015 to March 2016 across the children and young people's service noted to be between 0% and 46.2%. However, agency use in paediatric surgery noted to be between 4% and 27.4% across the same reporting period.
- General paediatrics had five consultants working from 8:30am until 5pm Monday to Friday. This included one consultant allocated to each ward. There was one consultant on call after 5pm. Saturdays and Sundays four consultants worked across most paediatric departments between 8:30am and 12pm. At all other times over the weekend there was one consultant on call and one paediatric oncologist on call for the oncology ward.
- Consultants for paediatric intensive care were split between the Glenfield Hospital and Leicester Royal Infirmary sites. There was consultant presence on each unit between 9am and 5pm Monday to Friday. Consultants were available on call out of hours and at weekends.

- Consultants working in paediatric cardiology were on site Monday to Friday between 8am and 5pm. At weekends, consultants provided ward rounds and presence in the mornings. The rest of the time, the consultants worked a non-resident on call system.
- A consultant paediatrician was available in the hospital during peak activity seven days a week. The escalation plan for the children's assessment unit (updated October 2015) established and confirmed their role during the escalation phase.
- Anaesthetic consultant and intensivists were available out of hours to provide anaesthetic advice and support for children's services.
- The paediatric inpatient units adopted an attending 'consultant of the week' system. This model of care was to improve quality, ensure good handovers and improve communication with patients and their families.
- We observed paediatric handover and neonatal handovers and saw they were thorough. The discussions included discussions about newly admitted children and those who were unwell or required clinical review.
- Specialist paediatricians were available for immediate telephone advice for acute problems twenty four hours a day for diabetes, oncology, haematology, cardiology, ECMO, cardiac surgery, general and ear, nose and throat surgery. Respiratory, allergy, immunology, neurology and gastroenterology specialist advice was available until 10pm and then covered by the on call paediatrician overnight.
- Only medical staff who were at specialist trainee level (a doctor who has between three and seven years' experience) or above could discharge a child admitted with an acute medical condition.

Major incident awareness and training

- The trust had a Part A major incident plan and Part B for clinical management group service area response plans, which ensured critical services were delivered in exceptional circumstances.
- Part B identified specific roles including measures put in place should a major incident take place. It identified responsibilities including coordinating activity using the Paediatric Network Major Incident Plan, a statement from the trust confirmed this was not currently in place and clarification was being sought however, work was on-going nationally to assess how the network functions due to be tested on June 2016.

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- Escalation plans were available for the Children's Hospital, paediatric intensive care and the ECMO Unit.

Are services for children and young people effective?

Outstanding



We rated the effectiveness of the children's and young people's service as outstanding.

We found:

- The children and young people's services took part in a comprehensive range of clinical audits to monitor and improve quality and outcomes. The findings of audits showed patient outcomes were the same as, or exceeded England averages.
- Outcomes data for the East Midlands Congenital Heart Centre (EMCHC) for April 2015 to March 2016 demonstrated no deaths reported following cardiac surgery since March 2015, with 6.3 fewer deaths occurring than predicted by a risk adjusted outcome model.
- The hospital was one of only three hospitals in England and Wales to provide extracorporeal membrane oxygenation (ECMO) care to children. Outcomes were monitored through audits, these showed ongoing improvements for patients.
- Staff assessed and responded to pain appropriately therefore patients had timely access to pain relief. Staff had access to a specialist children's pain team who performed daily ward rounds.
- The majority of staff were up to date with their appraisals with 94% completed.
- There was positive collaborative, multidisciplinary working which included staff across different specialties and a range of community based services. Services worked to provide care and share information. This demonstrated a holistic and coordinated approach to discharge, transfer or transition to other services.
- The children's hospital provided the Leicester Airway and Home Ventilation Service (LeAHVes) in collaboration with another community service. This

team won an award in 2015 recognising the collaborative work undertaken between hospital and the community to improve care for children and young people who require long-term ventilation.

- We saw examples of staff completing consent forms and they understood their role and responsibility regarding consent.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed eight evidenced based guidelines which included acute asthma, acute kidney injury, and urinary tract infection. All of these were within their review by dates and evidenced based.
- Staff had access to guidelines and protocols located on trolleys. For example one member of staff showed us guidelines on nasogastric (NG) intubation and feeding. We saw there were flow charts for staff to follow.
- A number of evidence based protocols, care bundles and policies including bronchiolitis (review December 2016), asthma management (review June 2019) and croup (review December 2016) were available for reference on discharge for children referred for acute medical treatment.
- We saw evidence of a clinical assessment tool for babies and children under two years with suspected bronchiolitis (a common lower respiratory tract infection affecting babies and young children under two years old) for use out of the hospital setting. Review of this document was due in 2015 post publication of the most recent National Institute for Health and Care Excellence guidance.

Pain relief

- A named consultant paediatric anaesthetist led the children's pain management team. In addition there were 1.4 whole time equivalent specialist children's pain nurses with non-medical prescribing skills.
- The team followed up where children were receiving morphine (a strong pain medication to relieve pain) and epidural pain relief (an injection of pain-relieving medicines into a space surrounding your spinal cord).
- The service was available Monday to Friday 9am to 5pm with nursing advice. Staff could make answerphone referrals at any time, these would be responded to during working hours.

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- Out-of-hours an anaesthetist was on call for complex pain issues.
- Babies, children and young people had access to a range of pain relief which included morphine infusions, epidurals, patient controlled analgesia (PCA) and regional pain relief.
- The service undertook pre-admission pain consultation with the child and family prior to extensive surgeries requiring epidural or morphine pain relief. Non-pharmacological therapies such as heat/cold packs, diversion and transcutaneous electrical nerve stimulation (TENS) therapy were offered.
- The pain team provided education and support for the multi-disciplinary team, pre-registration nurses and medical students.
- Nursing staff used a pain assessment scoring flowchart and child pain assessment tools. We reviewed two pain assessment charts and saw children's pain scores were escalated as per trust guidance.

Nutrition and hydration

- The 'Baby Friendly Initiative' is a worldwide programme. The Organisation and UNICEF established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding.' The neonatal unit achieved the 'World Health Stage Two Baby Friendly Accreditation' in 2013. Stage two of the programme involved the assessment of staff knowledge and skills.
- Nutritional requirements were calculated and recorded in the care plan. Staff supported women with their choice of feeding their baby.
- The service assessed nutrition by completing a malnutrition score proforma. This had a clear pathway for staff to follow depending on the result of the assessment.

Patient outcomes

- The trust scored 'about the same as other trusts' for six out of the eight questions related to effectiveness in the 2014 Care Quality Commission (CQC) Children and Young People's Survey. The remaining two questions scored 'worse than other trusts' which related to 'did members of staff caring for your child work well together?' and 'were the different members of staff caring for and treating your child aware of their medical history?'. This was not broken down to ward areas within the service.

- The clinical audit and quality improvement plan for 2015 to 2016 identified 117 audits the service was undertaking and the lead for each audit. Of the 117 audits 67 were in children's services, 24 in extracorporeal membrane oxygenation (ECMO) and 25 were in neonatology. It identified the children's service had taken part in a number of national audits, for example, the diabetes and epilepsy 12 audits.
- The hospital provided specialist services for patients including the Congenital Heart Centre and was one of only three hospitals in England and Wales to provide extracorporeal membrane oxygenation (ECMO) care.
- The Extracorporeal Life Support Organization report for the ECMO children's service published in July 2016 to show survival rates to transfer or discharge. Neonatal respiratory survival rates had improved each year since 2013. The paediatric respiratory patient's outcomes had improved overall since 2013, but had varied between 77 – 100% survival rates between 2014 – 2016.
- Due to a low number of ECMO units and variable activity reliable benchmarking was not possible however there was a national group which met to look at performance and activity data which Glenfield Hospital attended. Complications and shared learning were also discussed at national meetings to promote improvements.
- The National Paediatric Diabetes Audit April 2013 to March 2014 demonstrated a similar percentage of children have well controlled diabetes compared to the average for England. The indicator regarding 'diabetes control' was the same as the England average.
- The Epilepsy 12 National Audit January 2013 to June 2015 demonstrated significant improvement in care during its first five years.
- For the period December 2014 to November 2015 the trust had lower emergency admissions than the England average for the rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes.
- The multiple admission rates within 12 months for one to 17 year olds with asthma was 14.1%. This was just below the England rate of 16.5%. However, a comparison cannot be made for babies less than one year old, or for children with diabetes or epilepsy due to the small numbers of multiple admissions. The trust did not have enough re-admissions for elective specialties to make a comparison.

Services for children and young people

- Outcomes data for the East Midlands Congenital Heart Centre (EMCHC) for April 2015 to March 2016 demonstrated no deaths reported following cardiac surgery since March 2015, with 6.3 fewer deaths occurring than predicted by a risk adjusted outcome model.
- The unplanned surgical re-intervention rate within 30 days was not statistically different from the national average. Unplanned catheter re-intervention rate within 30 days was not statistically different from the national average. The data for one or more surgical procedure related complication was not statistically different from the national average.

Competent staff

- Appraisal rates at for the reporting period April 2015 to March 2016 averaged 94% across all staff groups within children and young people's services. This was better than previous years with appraisal rates at 81% for April 2014 to March 2015. All staff we spoke with said they were up to date with their appraisal.
 - Staff promoted to management positions were given orientation days by the trust. Orientation days included meeting with HR, discussing audits and new managers were given the opportunity to shadow other managers. One member of staff said they valued orientation days as it helped to support their transition into a management role.
 - Staff and student nurses worked to clinical competency booklets for example, cardiac catheterisation. We saw completed examples of these and saw nurses and senior nurses had signed and countersigned them.
 - All wards we visited had staff in link roles. The staff in link roles had the responsibility of keeping up to date with and informing staff of specific subjects, for example bereavement, safeguarding and breastfeeding. Where possible all nursing staff undertook a link role.
- A multi-disciplinary team which included the play team, speech and language specialists, occupational therapy and the Children's Hospital school supported children and young people with communication disorders, physical disabilities, long term conditions, special educational needs and end of life care.
 - Staff offered choice to all families with long-term conditions when entering the end of life phase of care, which included partnership working between community teams and a local children and young people's hospice.
 - Within the cardiac services a yearly Bereavement Day was organised by the specialist cardiac liaison nurses for families.
 - A community nursing team managed by another provider supported the Children's hospital. The service provided nursing and supportive family care to children aged zero to 18 years and their families who were under the care of a paediatric oncology or haematology consultant, from diagnosis and throughout the disease process. Hospital staff knew how to refer to this service.
 - Senior medical staff attended a regional general paediatric network, minutes from the meeting (March 2016) discussed topics which included patient information leaflets, regional radiology services and proposed regional website for Children's Specialised Health Services.
 - Paediatrics and Adult Liaison (including medical staff) coordinated transition to adult services for young people aged 16 and over. The process of transition started at 14 years of age. In addition, a lead paediatric liaison nurse worked for the service. The nurse worked with children and their families to ensure there was a seamless transition in care provision.
 - The trust had a transition to adulthood clinic located in the main outpatient department at the hospital. The clinic ran every Thursday and staff explained what to expect from adult services to young people.

Multidisciplinary working

- The children's hospital provided the Leicester Airway and Home Ventilation Service (LeAHVes) in collaboration with another community service providing care and support for children and families requiring special nursing care in a community setting. This team won an award in 2015 recognising the collaborative work undertaken between hospital and the community to improve care for children and young people who require long-term ventilation.

Seven-day services

- Seven day scheduled services for in-patients included x-ray, ultrasound scanning, computed tomography (CT) and magnetic resonance imaging (MRI).
- The trust provided a pharmacy service across all three sites, which was available Monday to Friday and Saturday and Sunday mornings. An on-call service operated outside of these hours to answer any questions staff may have.

Services for children and young people

Access to information

- The trust audited and recorded all information sharing agreements yearly, and reported to the information governance steering group for Caldecott Guardian information. Caldecott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The sharing agreements included guidance related to 'what and how data would be shared, how consent would be obtained, how dissent would be managed, what security would be in place to secure the information and which parties the information would be shared with.'

Consent

- Gillick competence refers to the assessment doctors could make in regards to whether a child under 16 years has the capacity to consent to treatment without parental or guardian consent. We reviewed children's and babies notes for evidence of consent processes and saw completed consent forms for specific investigations, for example, prior to surgery. Staff understood their role and responsibility regarding consent.
- The trust had an up-to-date consent to examination or treatment policy (October 2018) which included the Deprivation of Liberty Safeguards (DoLS), Mental Capacity Act 2005 guidance and Gillick competence.
- Staff received education on Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 as part of mandatory training. The most recent training figures provided by the trust demonstrated completion rates within children's services for allied health professionals as 39%, doctors were 44%, non-qualified nurses and qualified nurses as 63%. This was below the trust target of 95%.
- The trust had a safeguarding children's policy (review November 2018) which provided guidance for staff, a checklist to confirm parental responsibility. Staff confirmed and documented as part of the admission process.

Are services for children and young people caring?

Good



We rated the caring of the children's and young people's service as good.

We found:

- We observed positive, compassionate care and staff were sensitive to the needs of babies, children, young people and those close to them. Without exception, patients and those close to them were positive about their care and treatment.
- Care was person centred and staff recognised each child's ability and strengths taking into account their personal, cultural, social and religious needs.
- Children and young people services had consistently positive CQC inpatient survey and Friends and Family Test scores. Survey results from children and their family/carers showed a high level of satisfaction with results reflecting or exceeding the national average.
- Children and their families/carers were considered as active partners in their care. We observed nursing and medical staff communicating to patients, their parents and carers clearly, so they understood their individual treatment and they were fully involved in the care planning process.
- Staff provided opportunities for patients and their relatives to ask questions. We saw staff answering questions and ensuring patients and parents understood them through clarification. Staff recognised children's communication and sensory needs, for example using picture cards to explain an operation or supplying ear plugs for noise sensitivity.
- The service helped children, young people and their families to understand their thoughts and feelings about how they are being affected by illness by offering emotional support to help children and young people express themselves.

Compassionate care

- Throughout our inspection, we observed members of medical and nursing staff provide compassionate and

Services for children and young people

sensitive care which met the needs of babies, children, young people and their parents and carers. Patients and those close to them described care as “remarkable” and “couldn’t want for better”.

- Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations. All staff we observed smiled and introduced themselves to patients and those close to them.
- In the 2014 Care Quality Commission (CQC) Children and Young People’s Survey, for questions related to caring, the trust scored ‘about the same as other trusts’ for 26 out of the 27 (96%) and ‘better than other trusts’ for 1 out of 27 (4%).
- The teenage and young adult integrated cancer service undertook a patient experience survey in September 2015. General comments included, ‘excellent service, felt informed about the treatment, rooms were well equipped and we always felt looked after.’
- We reviewed the NHS Friends and Family Test results in the children and young people’s service for the period March 2015 to March 2016. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Data from the trust showed the average FFT score across children’s wards and departments was 96% between June 2015 and May 2016.
- We saw staff provide consistency of care to patients of all ages and abilities. Parents of one young person said their child was “treated no differently because they had Downs Syndrome”.
- Care was person centred and individual to each child, for example, we observed a member of staff offering a young man ear plugs because the ward was noisy.
- Patient involvement seemed excellent. We saw staff explaining everything to patients with a real focus on communication with the parents. One member of staff used picture cards to explain an operation.
- Staff made time to occupy patients on wards and engage in interactions and activities in particular when they had no parents or relatives around. One patient said, “Staff treat me as a person”.

Understanding and involvement of patients and those close to them

- We observed nursing and medical staff communicating to patients, their parents and carers clearly, so they understood their treatment and care. For example, we saw staff explaining resuscitation procedures and the risks involved. All patients and parents we spoke with said they felt involved and informed. One parent said “we are always given time” to discuss concerns with staff.
- Staff provided opportunities for patients and their relatives to ask questions. We saw staff answering questions and ensuring patients and parents understood them through clarification.
- Staff encouraged patients and those close to them to be involved in their care and treatment. We saw evidence of patient and parental involvement in patient records. Staff clearly documented patients or parental involvement and what decisions were made regarding care plans.
- We saw staff make sure patients and those close to them could find further information. Staff presented patients with information or signposted them to information online or other organisations.
- Staff spoke to patients in a child friendly way and the majority of staff spoke to patients directly before addressing those close to them.
- We observed a consultant providing clear information on discharge from the service to the patient and their parents as per the Royal College of Surgeons 2013 Standards for Children’s surgery.

Emotional support

- We saw staff providing emotional support to patients, their parents and carers. For example, we saw staff comforting and reassuring a parent who was crying as their child was taken into theatre.
- A community child and family support service nursing team managed by another provider supports the hospital. The service helped children, young people and their families to understand their thoughts and feelings about how they are being affected by illness by offering emotional support, using counselling techniques, and encouraging special therapeutic play to help children and young people express themselves. Hospital staff knew how to refer and used this service.

Are services for children and young people responsive?

Services for children and young people

Good



We rated the responsiveness of the children's and young people's service as good.

We found:

- The hospital provided specialist services for patients including the Congenital Heart Centre and was one of only three hospitals in England and Wales to provide extracorporeal membrane oxygenation (ECMO) care.
- Data from the trust showed positive referral to treatment times for non-admitted pathways and better than England average readmission rates.
- Services for children and young people met people's individual needs through accessing interpreting and translation services when required. The trust had specialist nurses who provided support to patients with learning disabilities.
- Parents and relatives had access to accommodation and facilities to make food and drinks. The trust could provide multi faith spiritual and pastoral support.
- Services for children and young people had process and information to enable patients and those close to them to make a complaint. We saw evidence of reviews, actions, and learning taking place.

However we also found:

- The trust were not meeting Facing the Future: Standards for Acute General Paediatric Services (2015) standards two and three. Every child who is admitted to a paediatric department with an acute medical problem was not seen by a healthcare professional (middle grade doctor) within four hours of admission. A statement from the trust confirmed there was not currently a link consultant paediatrician for each local GP practice or group of practices.

Service planning and delivery to meet the needs of local people

- The East Midlands Congenital Heart Centre was based at Glenfield Hospital, caring for patients with congenital heart disease from before birth to adulthood. Services provided were the internationally recognised ECMO unit, a 24 hours a day, seven days a week retrieval service, experienced cardiac team and the ability to see

patients close to where they live, through the East Midlands outreach service. The hospital was one of only three that provided the ECMO service in England and Wales.

- In addition, the hospital provided inpatient, outpatient and a paediatric intensive care unit for babies, children and young people across Leicestershire area.
- The Children's Hospital project board had a parent and carer representative. As part of the engagement, the service used social media to communicate with trust members.
- Out of 41,434 imaging tests 2,942 (7.1%) were conducted in a predominantly adult setting. We saw the environment was child/parent friendly with allocated pushchair 'parking areas', breastfeeding room, and the provision of age appropriate toys.
- The hospital had a dedicated anaesthetic room for children and young people. The room was decorated appropriately with cartoon characters and was a child friendly area to put children at ease.
- Children's and young people's services had a bereavement link nurse. The bereavement link nurse would support parents for bereavement or bad news. They also signposted and made referrals to other organisations such as hospices who could support parent and children emotionally.
- Parent and child information leaflets on pain relief after surgery were sent out pre-operatively for planned surgery and available on the wards for unplanned surgery.

Access and flow

- Between July 2014 and June 2015, for patients aged under one year old, the most diagnosed illnesses on emergency admission was 'acute bronchiolitis' (acute inflammation of the air tubes in the lungs) and 'other perinatal conditions,' conditions arising in the 20 to 28 weeks of development and the first to fourth weeks after birth. For patients aged one to 17, the most common diagnosis recorded on emergency admission was 'viral infection.'
- Data from the trust demonstrated clear admission pathways for the Children's Hospital, which included walk in and ambulance presentation via the emergency department or referral to the Children's Assessment Unit (CAU) by a health care professional. The service did not audit the length of time children spend in the CAU and therefore could not provide the data.

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- We reviewed the children's hospital 18 week referral to treatment performance data (June 2015 to May 2016) for admitted and non-admitted performance against each speciality. During the 12 month period the monthly range for admitted performance was between 72.7% (December 2015) to 88.6% (July 2015). This was worse than the England average of 95%.
- Non-admitted performance monthly totals confirmed 97.5% to 98.7% compliance against 18-week targets. This was better than the England average of 95%.
- For the period November 2014 to October 2015, the trust's readmission rate within two days of discharge for non-elective babies less than one year of age was low, indicating fewer individuals were re-admitted to hospital than the England average. The rate was better than the England average for non-elective one to 17 year olds.
- The trust had a higher length of stay for non-elective patients aged less than one year compared to the England average. The length of stay for non-elective patients aged one to 17 years was the same as the England average. Non-elective patients stay at short notice because of clinical need or because alternative care was not available.
- We reviewed data from the Women's and Children's Quality Dashboard (June 2015 to May 2016) for patients with a clinical management plan less than four hours after arrival. During this period the monthly range was 80% to 100% (July 2015 and December 2015, March 2016). For patients with a clinical management plan less than two hours after arrival the monthly totals confirmed 80% (July 2015 and December 2015, March 2016) to 100%. A Red, Amber, Green (RAG) status of reporting was used by the trust; this indicated how well the service was doing. An 80% to 90% range indicated an amber status and greater than 90% indicated green. Facing the Future: Standards for Acute General Paediatric Services (2015) Standard two states every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional (middle grade doctor) within four hours of admission. This meant the trust was not meeting the national standard.
- Facing the Future Together for Child Health (2015) Standard Three states there is a link consultant paediatrician for each local GP practice or group of practices. A statement from the trust confirmed this was not currently in place within the Children and Young

People's service. This meant the trust was not meeting the national standard. However, the paediatric department provided education sessions at learning events for GPs covering topics for acute and speciality care needs. There was a named doctor working on improving links and education with primary care givers.

- A community nursing team managed by another provider supported the Children's Hospital. The service provided short term and continuing nursing care to children and young people up to the age of 18 years. The services offered included wound care, passing feeding tubes and intravenous antibiotic therapy (the infusion of liquid substances directly into a vein).
- Podcasts (a digital audio file made available on the internet) on recognition of the sick child had been produced by a senior member of the medical staff for GPs to use in the community. These were accessible from the university hospitals website and included identifying the sick child, fits, faints and funny turns.
- Trust figures demonstrated between December 2015 and May 2016 142 (5.5%) out of 2439 outpatient clinics were cancelled. Reasons for cancellation included 'consultant other reason' (42), 'clinician annual leave' (27), strike action (16) and clinic cancelled (9).
- Between June 2015 and May 2016, 355 patients were offered an appointment to the paediatric cardiac surgery outpatients department, 14 (4%) of the 355 did not attend. For the paediatric cardiology outpatients 10,881 patients were offered an appointment 764 (7%) of the 10,881 did not attend for the same period.

Meeting people's individual needs

- Due to building work on Ward 30 (children's ward), children and young people of all ages (including teenagers) were mixed together on the ward. This meant there was limited opportunity for children and young people of the same age to be located with their own age group. Staff made all patients and their relatives/carers aware of this on admission.
- Staff had access to 24 hours a day seven days a week, interpreting service provided externally including the provision of British Sign Language interpreters. There was an interpreting and translation policy in the trust
- The trust had 2.5 whole time equivalent (WTE) Acute Liaison Nurses (ALN) who provided advice and support to patients admitted to hospital who had a learning

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disability. In addition, a flagging system linked to the Leicestershire Learning disability register alerted the team of any admission of a patient who had a learning disability.

- Patients living with a learning disability were assessed using standardised nursing and medical documentation. Where patients had their own hospital profiles they were asked to bring them into hospital with them. On receipt of notification of an admission the ALN would contact the ward and telephone assess the level of priority in terms of their visit i.e. patients with more complex needs may be seen more quickly. However all inpatients were to be seen or the ward contacted within 24 hours of admission. On attendance, the ALN would assess what reasonable adjustments were required in addition to speaking to carers about the care needs of the patient.
- Pastoral, spiritual and religious support was available to patients, relatives and staff. The Chaplaincy team comprised of Christian, Hindu, Muslim and Sikh chaplains, as well as the country's first paid non-religious carer who, focussed on meeting the needs of people who did not identify with a religious belief. Volunteers from various faiths and beliefs, including Baha'i, Buddhist, Jain and Jewish representatives, also supported the team. This service was provided 24 hours a day seven days a week on-call and where possible a representative of the patient's own faith would attend. The service was widely publicised through posters, leaflets and the trust website.
- A Chapel and Prayer Room (with washing facilities) was available at this hospital and met the diverse religious and spiritual needs of patients and staff. Rooms provided a quiet place for private prayer, meditation and contemplation and were open to everyone.
- The trust engaged with local faith representatives through the chaplaincy and through representation on the Trust's Equality Advisory Group. This group advised on various faith issues including modesty and patient food.
- Anaesthetic rooms were equipped with toys and equipment designed to distract children while they waited for their procedure. For example, staff used bubbles, books, tablet devices and colouring books to put children at ease.
- The trust had a chaperone policy (review 2019) giving specific reference to children and young people. During

our inspection, staff told us they were aware of the policy. We saw signs displaying information regarding the role of the chaperone and how to request this if required.

- The hospital had nine double rooms for parents to stay at the hospital. Parents had access to a kitchen, washing machine, and showers. This was important as some families did not live near to the hospital and it enabled parents to be close to their children.
- The trust scored 'about the same as other trusts' in the four responsive questions from the 2014 Care Quality Commission (CQC) Children and Young People's Survey. The four questions were:
 - Did you have access to hot drinks facilities in the hospital?
 - How would you rate the facilities for parents or carers staying overnight?
 - Did the hospital give you a choice of admission dates?
 - Did the hospital change your child's admission date at all?

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Patient Information and Liaison service (PILS). We received a mixture of responses from parents about how or who to approach should they have a complaint. Some parents were unaware of the complaints guidance whilst others confirmed they knew how to access this service.
- Feedback cards and comment boxes for parents to use were available throughout the service.
- The trust had a complaints procedure to enable complaints to be made. Leaflets were available for families within the Children's Hospital and the outpatient area.
- Data provided by the trust showed there had been 24 made to the children's service between December 2015 and May 2016. We reviewed two complaints and we saw there was clear evidence of review, actions taken, lessons learnt, time scales and outcomes documented.

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Are services for children and young people well-led?

Good



We rated the leadership of the children's and young people's service as good.

We found:

- There was a clear vision and strategy for the service and staff knew about plans for the service. Staff demonstrated and could articulate the trust vision and values.
- The trust had a regular internal and clinical audit programme to monitor performance. Services identified actions, learning and communicated them to staff.
- There was a positive, open, and supportive culture within the service.
- Leaders engaged staff through a variety of formats and staff we spoke with felt listened to and could approach leaders openly with concerns.
- There were positive examples of innovation with the development of a new electronic patient observation system and skype clinics.

However we found:

- The service does not have a non-executive director lead representing the service at board level.

Vision and strategy for this service

- A separate 'Clinical Vision and Strategy for Children's services 2016' was in place, which identified four strategic goals to provide an age-appropriate service for children and young people with a focus on outstanding, compassionate clinical care.
- The majority of staff could articulate the trust's vision and the values, which was to deliver 'Caring at its best' for everyone who visited the trust. Underpinning this was the trust values of; 'We treat people how we would like to be treated'; 'We do what we say we are going to do'; 'We focus on what matters most'; 'We are one team and we are best when we work together' and; 'We are passionate and creative in our work.' We saw all these values displayed by staff on our inspection.
- University Hospitals of Leicester NHS Trust had a detailed five-year integrated business plan, which

covered 2014 to 2019. Part of this plan was to move to a single site service for children and young people. The majority of staff we spoke to about this knew about the plans and viewed them positively.

Governance, risk management and quality measurement

- The trust divided the services into seven Clinical Management Groups. Children's service was in the Women's and Children's group. Quality governance structures were identified within this structure. The organisational diagrams for governance showed a comprehensive governance system in place which identified the lead persons for each area.
- There was an executive lead for the Children's Hospital Configuration Board however; the service does not have a designated non-executive director lead representing the service at board level.
- The trust conducted clinical and internal audits to monitor quality and performance. Wards displayed ward performance and assurance on notice boards in staff rooms, and publically on notice boards. Notice boards displayed performance audit data for example, nutrition, discharge planning and cannula care. Wards identified areas for improvement for example in May 2016 the children's ward scored 63% for discharge planning this being a focus of improvement for the coming months.
- Staff and leaders knew about the key risks to the service. This included staffing levels and the future delivery of some services. We saw these risks were included on service risk registers. Managers we spoke with had included risks as part of their ongoing business plan. For example, recruitment for staff had been included in the business plan. However, staffing shortfalls had been on the trust risk register since 2006.
- The trust had systems in place to enable the review of performance, risks and incidents. For example, clinical governance meetings, quality and safety meetings, and monthly trust board level meetings discussed incidents, complaints, performance and risks. Managers in the women and children's clinical governance group fed back performance and key issues to the board.
- The trust's SAC monthly meeting (April 2016 and May 2016) demonstrated evidence of learning outcomes and

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trust board priorities. A SCR action plan devised with other partner agencies demonstrated key learning themes for the trust such as ensuring the central computer system recorded multiple attendances.

Leadership of service

- All staff said they felt supported by their leaders and had confidence in them. Leaders knew about the issues affecting their services. They could describe and pinpoint to the inspection team what needed to be improved and how their services could develop.
- The majority of staff we spoke with knew about the trust whistleblowing policy and were comfortable raising concerns with senior nursing or medical staff.
- All staff we spoke with said leaders were approachable. Some staff we spoke with provided examples of when they had escalated concerns for example, staffing levels, to leaders.
- Leaders were visible on wards. All staff we spoke to said local leaders were visible and often seen on wards.
- However, some staff said they did not see senior managers on wards and didn't know who they were.

Culture within the service

- Staff described a flexible supportive culture at the hospital. Staff said they had strong working relationships, built on working hard for each other and ensuring they socialised together. Managers praised staff for "pulling together when the pressure was on".
- Staff said they felt valued and respected by both their peers and leaders. Staff were proud of where they worked and said there was an open and honest culture encouraged by leaders.

Public engagement

- The NHS Inpatient survey looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015. Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust. Responses were received from 547 patients at this trust. With the exception of 'Cleanliness of rooms or wards' the trust received a rating of 'about the same' on how performance compared with most other trusts. Cleanliness of rooms or wards received a rating 'worse than' most other trusts.
- The NHS England 'Neonatal Survey 2014' survey results for Leicester neonatal service compared to national

average results showed most of the trusts ratings were the intermediate 60% of trusts. The 2014 survey of parents' experiences of neonatal care involved 88 hospital neonatal units in England.

- Wards used the friends and family test and comment cards to obtain patient feedback.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations.

Staff engagement

- Listening into Action (LiA) is a comprehensive, outcome-oriented approach to engage all the right people behind quality outcomes. Ward 27 ran a LiA event in 2014 to improve and contribute to service planning and delivery making a positive difference to young people receiving chemotherapy from the day care service.
- Senior nurses and managers engaged staff through a variety of formats. This included posters, notices in the staff room, communication folders, emails and telegrams. The majority of staff we spoke with felt engaged, listened to and communicated with by their managers.

Innovation, improvement and sustainability

- At the time of our inspection, services for children and young people were developing the electronic patient observation system (EPO). A roll out of this system was due to begin in July 2016 and there were clear plans to roll the system out to all trust sites.
- Consultants were developing weekly skype clinics for babies waiting for further cardiac treatment or procedures. This enabled consultants to review patients without parents having to travel into hospital with their children.

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- The children's service could not meet staff demand to access advanced paediatric life support courses. Due to limitations of education funding the service were exploring different ways of funding to meet the current need.
- The pain management service won the national Grünenthal award for pain relief in children in 2016. The

Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

End of life care

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

End of life care and palliative care services at University Hospitals Leicester NHS trust are provided across all wards and departments, as the trust does not have a dedicated palliative care ward in any of the three hospital sites.

The specialist palliative care team (SPCT) work closely with other health professionals in the hospital and community to ensure that all patients in their care achieve the best possible quality of life.

The specialist palliative care team who supported ward staff to deliver care to patients at the end of their life, are available five days a week, Monday to Friday between the hours of 8am and 6pm and between 9am to 1pm on Saturday and Sunday. Out of hours advice is provided by a dedicated telephone advice service based at the nearby hospice.

The specialist palliative care team is comprised of 15 registered nurses, which equates to 12.93 whole time equivalent (WTE) nurses, who provide symptom management advice and support to all patients and professionals involved in the care of the patient.

There are five palliative care consultants covering 3.5 WTE posts, across the three sites

Total number of deaths from April 2014 to March 2015 for the trust was 2937. For the period April 2015 to March 2016 the number of deaths was 2940. The trust is in the top five percent of trusts nationally for deaths that occur in hospitals, which was expected due to the size of the trust.

The specialist palliative care team accepts referrals for patients with progressive life threatening illness when life expectancy is likely to be less than one year. Referral criteria include difficult pain and symptom control, complex psychosocial problems and/ or specialist needs related to end of life care.

Referrals to the specialist palliative care team for the period April 2014 to March 2015, were 1571 cancer and 435 non-cancers. As a percentage this equates to 78% cancer and 22% non-cancer. The total referrals were 2006 for this period.

For the period April 2015 to March 2016 the total referrals for cancer patients were 1672 and for non-cancer patients it was 600. As a percentage, this equates to 74% and 26% total referrals 2272 for this period.

We visited eight wards and departments at the hospital including the cardiac wards, the intensive care unit mortuary, the hospital chapel, and the clinical decisions unit. We spoke to 25 members of staff including nurses, doctors, health care assistants, mortuary, bereavement and chaplaincy staff. We also spoke to three patients who were at the end of their life and six relatives.

We reviewed five medical and nursing care records of patients at the end of life and 25 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders. We observed the care provided by medical and nursing staff on the wards. We received comments from the public listening event, which was held before our inspection and from people who contacted us separately to tell us about their experiences.

End of life care

Summary of findings

Overall, we rated end of life care services as requires improvement. We rated safe, effective and well led for end of life care services as requires improvement, with, responsive and caring as good.

- The medical staff levels were not in line with the recommendations from the National Council for Palliative Care who recommend that there is one whole time equivalent (WTE) consultant for every 250 beds. The service had 3.5 WTE and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended.
- The trust had 82 syringe drivers that were in line with best practice guidelines, though many were missing. This meant only ten were ready for use. This meant another syringe driver was being used instead, which did not meet the NHS patient safety guidance.
- Out of 25 Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR), nine were completed correctly (38%).
- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust scored lower than the England average for all five Clinical KPIs.
- The trust had undertaken an audit in April 2016 in response to the National Care of the Dying Audit 2016, and an action plan had been developed to address the KPI's that had not been achieved.
- The service does not have its own risk register the incidents were not the trust wide risk register.
- There was no strategic plan for end of life care throughout the trust.
- The service did not have a non-executive director representing end of life care at board level.

However:

- We found care records were mostly maintained in line with trust policy.
- Staff understood their responsibilities in following safeguarding procedures.
- Care and treatment was delivered in line with recognised guidance and evidence based practice. The last days of life care plan was in use throughout the trust.

- The trust had effective multidisciplinary working in place.
- Staff were seen to be compassionate and we observed them treating patients and their families with dignity and respect.
- A bereavement service was offered on all three sites with staff available to support family members with practical and support issues after the death of a patient.
- The chaplaincy service provided a 24 hour, seven days a week on call service for patients in the hospital, as well as their relatives.
- Patients who were referred to the specialist palliative care team were seen according to their needs.
- The specialist palliative care team were committed to ensuring that patients receiving end of life care services had a positive experience.
- The trust had a rapid discharge home to die pathway. Discharge in these circumstances was arranged by the palliative care clinical nurse specialist and could be facilitated within a few hours for patients wishing to return home.
- Staff spoke positively about the service they provided for patients. High quality, compassionate patient care was seen as a priority. Staff within the specialist palliative care team spoke positively and passionately about the service and care, they provided for patients.
- The trust had recruited a bereavement nurse specialist in December 2015 who worked across the three hospital sites and closely with the specialist palliative care team (SPCT).

End of life care

Are end of life care services safe?

Requires improvement



We rated the safety of end of life care services at Glenfield Hospital as requires improvement.

We found:

- There were not sufficient, appropriate syringe drivers available which adhered to the current NHS Patient Safety Guidance to meet the needs of people receiving end of life care on all of the wards we visited. This was not being given sufficient priority and an older type of syringe drivers which lacked some safety features was in use alongside a newer type. The drug measuring systems in each pump was different, which significantly increases the risk of drug errors being made.
- The medical staff levels were not in line with the recommendations from the National Council for Palliative Care who recommend that there is one whole time equivalent (WTE) consultant for every 250 beds. The service had 3.5 WTE and would require 7.0 WTE to provide cover to the three sites. The staffing was 50% lower than recommended.

However, we found that:

- Care records were maintained in line with trust policy. Patient records were kept securely when not in use.
- Staff understood their responsibilities in following safeguarding procedures.
- All the members of the palliative care team we spoke with were knowledgeable about the Duty of Candour.
- The trust had implemented individualised care plans for patients requiring end of life care. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2015.

Incidents

- We looked at the trust incident reporting policy which was up to date.
- The specialist palliative care team (SPCT) told us they were familiar with the process for reporting incidents, near misses and accidents using the trust electronic

incident reporting system. Any serious incidents would be investigated through the use of root cause analysis and where necessary further training would be arranged.

- Between May 2015 and April 2016, there were no serious incidents or never events reported in the end of life care services at Glenfield Hospital. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Staff understood their responsibilities to raise concerns and told us they felt well supported and were encouraged to report incidents.
- Mortuary staff told us they were unable to access the trust's electronic incident reporting system, and had to rely on their manager to report any incidents should they occur. Mortuary staff told us, they often did not receive any feedback about any incident they reported. The trust told us mortuary staff did have access to incident reporting system.
- All the members of the palliative care team we spoke with were knowledgeable about the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- For the period May 2015 to May 2016, the service reported four medication errors at Glenfield hospital. We saw documentation that showed all of the medication errors had been investigated and action plans commenced, with lessons learned.
- The trust had a 'Being Open' Leaflet, which was given to patients and relatives as part of the process for serious incidents, never events and those incidents that had undergone a comprehensive internal investigation.

Medicines

- The trust used syringe pumps for patients who required a continuous infusion of medication to control their symptoms. However, not all of the syringe pumps met the current NHS Patient Safety Guidance which recommends the use of syringe pumps that have specific alarm features and are tamperproof.

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- At the time of our inspection, the trust had a shortage of syringe pumps that met current NHS patient Safety Guidance and the SPCT told us there were only ten of these pumps for patients throughout the trust.
- Staff told us when patients were discharged to the community; the recommended syringe pumps often went with the patient and were not returned to the hospital. The hospital had no system in place to track these syringe pumps. At the time of our inspection, the trust could not account for 61 of their syringe pumps and there was no planned programme to replace them. This meant there was a risk that there would not be syringe pumps available when patients needed them, and there was not a plan in place to address the shortage.
- The shortage of syringe pumps meant staff were using an alternative syringe pump that was not tamperproof and did not have the recommended alarm features. This was not in keeping with the trust policy. The type of pump being used as an alternative has been subject to a patient safety alert in December 2010.
- The measurement of drug dosage varied in the two types of pump being used, one was measured in millimetres, the other in millilitres, this lack of consistency increased the risk of drug errors being made. As some patients could also be discharged with syringe pump in place this also increased the risk to them in community settings as a different type of syringe pump with additional safety features was used there. Therefore the majority of syringe drivers being used throughout the trust were not designed to protect patients from harm when used to administer a continuous infusion of medication.
- Two nurses from the SPCT were non-medical prescribers and one was undertaking training to become a non-medical prescriber. Non-medical prescribers are nurses that are able to prescribe any medicine for a health condition, within their field of expertise.
- The trust had a protocol for the prescribing anticipatory medication. Anticipatory medicines are prescribed to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may occur as a patient reaches the end of their life.
- We reviewed the medicines administration records of five patients who were receiving anticipatory medicines. We found these medicines had been appropriately prescribed and administered.
- End of life care services at this hospital followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS61. This quality standard defines clinical best practice about how people are prescribed antibiotics in accordance with local antibiotic formularies. Additionally, nurses followed the standards set out in the nursing and midwifery council (NMC) standards for medicine management.
- We saw a palliative care pharmacy protocol on the hospital's intranet system. The pharmacist told us if a palliative care patient is flagged on the system, then a quick list of standard prescriptions is highlighted. The pharmacist said this reduced the likelihood of a medication error as it is all prescribed for the doctors to initiate.

Records

- We examined five sets of patient records for end of life care patients throughout our inspection; all of them were clear, legible and up-to-date.
- Patient records were kept in secure trolleys at the end of each bay or near the nurses' station. These records were clear, legible and up to date. Records included completed risk assessments for example, falls, nutrition and pressure relief. Patients were cared for using relevant plans of care to meet their individual needs.
- The SPCT had created emergency healthcare plans for patients known to them. Staff working in the community could view these but not update them.
- The SPCT had a daily huddle, during which they reviewed the records of their patients to ensure continuous assessment of their needs.
- The bereavement office issued medical certificates of cause of death which enabled the deceased's family to register the death. We found the death certificates had been issued within 14 days of death or cremation and the forms had been signed in accordance with the Births and Deaths Registration Act 1953.

Safeguarding

- There were up-to-date trust wide safeguarding policies and procedures in place, which were accessible to staff via the trust's intranet site.

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- All the staff we spoke to in the SPCT were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding team.
- None of the staff we spoke with in the SPCT could recall a recent safeguarding incident regarding a patient receiving end of life care.
- Staff who provided end of life care had received mandatory training in safeguarding children and vulnerable adults. We saw data that showed 100% of the specialist palliative care team were trained to level two in children's safeguarding and 93.8% were trained to level two adults safeguarding. This was better than the trusts own target of 95%.
- The specialist palliative care team did not provide end of life care for patients below age of 18 years.

Mandatory training

- There was variability in the levels of compliance with mandatory training within the specialist palliative care team. Up to the end of April 2016, staff had achieved 100% compliance with infection control, equality and diversity and safeguarding children modules. Fire, health and safety, were recorded at 81.3%, moving and handling at 87.5%, information governance, conflict resolution, safeguarding adults and health and safety were all recorded as 93.8% and resuscitation training which was recorded as 81.3% compliance.
- End of life care training was not mandatory. However, the specialist palliative care team had devised a comprehensive end of life care training schedule for nursing staff which they delivered on a weekly basis. Each training session was ten minutes long, in order to ensure it did not interfere with workloads.
- We spoke with two porters who told us they had received training in moving and handling but had not received specific end of life care training. They told us they had received a three hour induction when starting the job and then they were expected to shadow an experienced porter.

Assessing and responding to patient risk

- We reviewed the nursing records of five patients receiving end of life care at this hospital. Risks such as falls, malnutrition and pressure damage were assessed. For example, we saw the Malnutrition Universal

Screening Tool (MUST) used to assess a patient's malnutrition risk and the Waterlow risk assessment tool was used to assess patients' risk of pressure damage. All of the records we saw were completed correctly.

- The trust had an individualised care plan for the last days of a patient's life. During our inspection we found that patients when entering the last days of life, were placed on the individualised care plans appropriately.
- However, on one ward we found that a fluid balance chart for an end of life care patient was incomplete and inaccurate due to incomplete readings. There were also no pain assessments completed for this patient despite being on a syringe driver. We saw documentation that showed that the syringe driver had not been checked in 24 hours. An alternative syringe pump was being used for this patient which was not tamperproof and did not have the recommended alarm features.
- Nursing staff used an early warning score (EWS), to record routine physiological observations such as blood pressure, temperature and heart rate. This score was used to monitor patients and prompt staff to follow clear procedures, should a patient's vital signs fall out of expected parameters. This meant that there was a system in place to monitor patient risk, including those patients receiving end of life care. We saw examples of care being escalated when a patient's condition had deteriorated. We saw evidence of a treatment escalation plan in the patient's records. Treatment escalation plans outline the level of intervention required should the patient's condition deteriorate.
- Intentional rounding took place for all patients receiving end of life care. Dependent on the individual patient's level of risk, these checks were conducted between one to four hourly intervals. Intentional rounding was an organised process where nurses carry out regular checks with individual patients at set times, normally hourly.
- The trust had devised the 'BEST SHOT' assessment, which was an additional pressure area checklist that was completed at the same time as intentional rounding documentation. This could only be completed by a registered nurse.

Nursing staffing

- The trust did not have dedicated palliative care beds, which meant that end of life care was provided

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throughout the trust. General Nurses provided care and treatment for patients requiring end of life care with support from the specialist palliative care team on general medical and surgical wards.

- There were 15 palliative care nurses in the specialist palliative care team, equating to 12.93 whole time equivalent (WTE) nurses. However, due to sickness and absence the specialist palliative care team staffing levels were reduced to 10 nurses, or 8.93 WTE nurses.
- The SPCT told us the reduction in staff meant that ward/department based training on end of life care had reduced.
- There were 31 end of life care champions attached to most of the wards throughout the hospital. End of life care champions were responsible for developing, in conjunction with the SPCT, standards and quality of care for palliative and end of life care patients.

Medical staffing

- There were five palliative care consultants in the specialist palliative care team equating to 3.5 WTE staff members. This did not meet recommendations by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care, which states there should be a minimum of one consultant per 250 beds. This meant that the trust would require 7.0 WTE doctors and the trust is currently running at 50% of the recommended medical staff rate. It was not clear what the plans were in the trust to address this.
- End of life care patients were reviewed on the wards on a daily basis and sometimes more than once a day as needed. We saw an example where an end of life care patient had been reviewed by medical staff twice the day before due to their deteriorating condition.
- We spoke with four doctors, all told us they had good access to and support from, the consultants within the specialist palliative care team.
- Weekend and out-of-hours on-call advice for staff was provided by a consultant employed by the local hospice. Staff could use this facility to access specialist advice and support if a patient was identified as at the end of life.

Major incident awareness and training

- The trust had a major incident plan, which was readily available to staff via the trust's intranet. The plan detailed the role of the mortuary in arranging to receive and manage the deceased, liaising with the police and the Coroner in the event of a major incident.
- The mortuary manager was very knowledgeable about the role of the mortuary if there was a major incident. They told us about the local facilities that they could use if there was an increase in the requirement for extra storage facilities. For example transferring the deceased between sites.
- The two porters we interviewed at Glenfield hospital stated they had not heard of a major incident plan and would not know what procedure to follow in the event of a major incident.

Are end of life care services effective?

Requires improvement



We rated the effectiveness of end of life care services at Glenfield Hospital as requires improvement because:

- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs) and the trust scored lower than the England average for all five Clinical KPIs. The trust did not have a lay member on the trust board with a responsibility for end of life care and there was a lack of formal training in relation to communication skills for staff.
- Out of 25 Do Not Attempt Cardio Pulmonary Resuscitation' orders (DNACPR), six were completed correctly (30%).
- The Specialist Palliative Care team told us they had not received any training on The Mental Capacity Act 2005. Nursing staff we spoke with had a basic awareness and understanding of Deprivation of Liberty Safeguards, but not of The Mental Capacity Act 2005.

However;

- All of the records we reviewed demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This guidance defines clinical best practice within end of life care for adults.

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- Staff were using the trust's end of life-individualised care plans consistently where patients had been identified as end of life to ensure they received evidence based end of life care.
- Patient's symptoms were managed and medication was prescribed for anticipatory medicines (medication that patients may need to take to make them more comfortable).

Evidence-based care and treatment

- Staff assessed patients' needs and delivered care and treatment in line with National Institute for Health and Care Excellence (NICE) guidance.
- All of the records we reviewed demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This guidance defines clinical best practice within end of life care for adults.
- Following the withdrawal of the Liverpool Care Pathway, the trust had developed and implemented individualised care plans for patients on the end of life care pathway. The individualised care plans recognised the five priorities for end of life care as set out by the Leadership Alliance for the Care of Dying People (2014).
- Staff were using the trust's end of life-individualised care plans consistently to ensure they received evidence based end of life care.
- The Specialists Palliative Care Team (SPCT) were able to tell us about the current guidance relating to end of life care.
- The trust participated in the Transforming End of Life Care in the Acute Hospitals programme (Transform programme). The programme aimed to improve the quality of end of life care within acute hospitals across England. It focuses on both the quality of care provided by acute hospitals, as well as the role acute hospitals have that provide care for people who are approaching end of life.
- One of the key elements of the Transform programme is the Amber Care Bundle, this is a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.
- Across the three hospital site, 44 wards were using the Amber Care Bundle. End of life care facilitators within the specialist palliative care team (SPCT) had launched the Amber Care Bundle and had supported staff in its implementation.

Pain relief

- Patient's symptoms were managed and medication was prescribed for anticipatory medicines (medication that patients may need to take to make them more comfortable). We checked medication administration records and found that both records demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms.
- We saw evidence of patients regularly being assessed for pain and given medication in a timely fashion. For example we saw an end of life care patient on a ward we inspected had undergone an assessment of their pain level which resulted in having their medication changed to control this.
- We were told patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief.
- We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- We saw the core standards for pain management services were being met in all of the medical notes we reviewed. The core standards for pain management in England are a comprehensive index of recommendations and standards for pain management.
- However, we saw documentation that showed the trust had not undertaken any audits on pain relief during 2015 or that any staff had received practical training on the use of syringe drivers for end of life care patients. The trust stated a training video had been produced for staff to view as a refresher and 'how to' when the specialist palliative care team (SPCT) were not available to support them in person.

Nutrition and hydration

- We reviewed five sets of nursing records for patients in the last days of life and found patients were screened for their risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). This is a five-step

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screening tool to identify patients who are malnourished, at risk of malnutrition and to ensure those who were nutritionally at risk were identified accordingly.

- Where interventions were required we saw these documented on the patient's daily record. For example we saw an entry from the dietician on one of the wards we inspected, where a patient required extra nutritional supplements; this was because there was a reduction in the patient's appetite which was a recognised aspect of their illness.
- Patients were encouraged to eat and drink as and when they are able to and for as long as they were able to in their last days of life. Families were also encouraged to support and help their relatives to eat.
- We looked at the menu on each ward we visited. The menu had a main section and one for cultural meals which included kosher, halal, vegetarian and vegan options. Staff told us that patients receiving end of life care could also order from the children's menu, this was because there were some end of life care patients preferred the children's menu choices.

Patient outcomes

- The trust was not contributing data concerning palliative care to the National Minimum Data Set (MDS). The National Council for Palliative Care collects the MDS for specialist palliative care services for palliative care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England.
- The trust had taken part in the End of Life care Audit – Dying in Hospital 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). Where the trust had not achieved the organisational KPI's these were because there was no lay member on the trust board with a responsibility for end of life care and there was a lack of formal training in relation to communication skills for doctors; nurses; health care assistants; (HCAs and allied health professionals).
- The trust scored worse than the England average for all five clinical KPI's. Where the trust had scored worse than the England average this was because the trust did not perform well against documented evidence at the end of a person's life.

- The trust had undertaken an internal audit in April 2016 in response to the findings of the 2016 National End of Life Care Audit – Dying in Hospital. An action plan was developed to address the KPI's that had not been achieved. Staff told us they were currently working to improve outcomes for patients at the end of their life.
- In January 2016, the trust started a review of patients' preferred place of care and preferred place of death. This was the first time the review had been undertaken.
- The trust did not contribute to the National Bereavement survey. The National Bereavement Survey aims to assess the quality of care delivered in the last three months of life for adults who died in England and to assess variations in the quality of care delivered in different parts of the country and to different groups of patients.
- The specialist palliative care team (SPCT) had commenced conducting self-audits in response to the results of the national Care of the Dying audit to monitor their own improvement.

Competent staff

- At the time of our inspection, there were 31 end of life care champion link nurses on the wards across Glenfield Hospital who championed end of life care. Link nurses or champions promote good practice for end of life care and have undertaken specific training relevant to their roles.
- The specialist palliative care team had undertaken the Quality End of Life Care for All (QELCA) training. Quality End of Life Care for All (QELCA) is an education programme, delivered by hospices for nurses working in other healthcare settings. The training is concerned with end of life care education. QELCA training was undertaken in conjunction with a local hospice four times a year for ward sisters and matrons.
- We saw documentation that showed all members of the specialist palliative care team received appraisals as well as clinical supervision and these were up to date.
- The specialist palliative care team clinical nurse specialists were able to access clinical supervision from a local hospice. A palliative medicine consultant led these supervision sessions on a bi-monthly basis.
- The trust did not participate in the Gold Standards Framework accreditation scheme (GSF). The GSF is a systematic, evidence based approach to improving care for all patients approaching the end of life.

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- The specialist palliative care team (SPCT) undertook regular teaching every week on a number of subjects for trust staff. An example of this was training undertaken recently for palliative and end of life care ward link nurse champions. However, we were told that the ability to provide this training was restricted due to staff shortages.
- Training was also undertaken on AMBER care bundles, QELCA, communication skills training, included breaking bad news, the five priorities for care and individualised end of life care plans.
- The specialist palliative care team provided 'shadowing' opportunities for all levels of staff. This allowed more inexperienced staff to work alongside a member of the specialist team to develop their own skills and knowledge.

Multidisciplinary working

- Patients receiving end of life care received support from an end of life care multidisciplinary team (MDT). This included the specialist palliative care team consultants, nursing staff, occupational therapists, physiotherapists, oncologists and other relevant professionals. The chaplain and the bereavement team were also part of the MDT for end of life care patients.
- The specialist palliative care team staff told us that members of the team, tried to attend as many multidisciplinary team meetings as possible. These were undertaken to help identify and coordinate care for patients approaching the end of their life or requiring supportive care.
- The specialist palliative care team attended the cancer multi-disciplinary meetings and either received or self-referred patients from the meeting.
- The specialist palliative care team had a good and effective relationship with the local hospice and ensured that patients nearing the end of life, who had expressed a wish to be referred to the hospice, were referred in a timely way. However, the trust did not audit referrals to the hospice so they were unable to monitor their performance.
- Staff in accident and emergency and in the intensive care unit told us of the good relationship between themselves and the specialist palliative care team.

- All patients receiving end of life care were discussed in the daily huddle and at the specialist palliative care multi-disciplinary meetings. The daily huddle is a short gathering of the specialist palliative care team (SPCT) to discuss new information and each patient's care.
- We attended a daily 'huddle meeting' with the specialist palliative care team (SPCT), and observed them discussing new patients and patients already known to them.
- The specialist palliative care team worked closely with the patient discharge team to ensure patients nearing end of life could undergo a rapid discharge home or to a 24 hour care facility in the community.

Seven-day services

- The specialist palliative care team worked Monday to Friday 08:30am to 5pm. A specialist palliative care nurse was on call between 9am and 1pm at the weekends.
- There was a dedicated advice line at a local hospice for professionals and members of the public to call out of hours.
- The specialist palliative care team told us that rapid discharges could be undertaken seven days a week. We requested information from the trust concerning any audits of this. We were told the trust does not collect data on timescales. This meant they were unable to monitor their performance.
- We were told the specialist palliative care team worked closely with a local hospice and the hospice at home team to facilitate rapid discharges.
- The chaplaincy service provided pastoral and spiritual support, and was contactable out of hours on a 24 hour basis.
- The mortuary provided a 24 hour, seven day a week service to both the trust and the community.

Access to information

- The service had a patient register that trust staff could access via the trust's centralised, electronic patient co-ordination system. However, staff working in the community, for example, GPs, district nurses and hospice at home teams could not access this system.
- GP's were informed through an end of life GP referral form by fax if a patient was being rapidly discharged from hospital.

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- Information needed to deliver end of life care was available to staff in a timely and accessible way. There was good access to the specialist palliative care team and relevant guidance was available on palliative care and end of life care through the trust's intranet.
- We saw that medical and nursing notes were easily accessible within clinical areas when required. Ward based nursing staff were able to locate specific information within patient records. All members of the MDT wrote in the same place. This meant all members of the MDT had access to all relevant notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not see any end of life or palliative care patients deprived of their liberty during this inspection.
- Patients and relatives told us that staff did not provide any care without first asking their permission.
- Signed consent forms were evident in all the patient records we examined. This demonstrated that staff obtained consent to treatment appropriately
- Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training were not delivered as part of the mandatory training programme across the trust.
- Nursing staff we spoke with told us they had not received training on the MCA. They had a basic awareness and understanding of DoLS, but not of the MCA. The MCA is a piece of legislation applying to England and Wales, its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The DoLS is part of the MCA. DoLS aims to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Anybody under a DoLS application must first have had a mental capacity assessment and be found to lack mental capacity to make a decision with regard to the situation they find themselves in. The trust told us that MCA training was delivered alongside DoLS and consent training.
- We requested from the trust any audits from the last 12 months on staff completing mental capacity assessments and any recent audits on DoLS applications for the End of Life Care Service.
- The trust stated they had not undertaken any audits, but instead had embarked on a Mental Capacity awareness project which had commenced in December 2014 for the purpose of improving awareness, understanding and compliance from staff with both the Mental Capacity and the Deprivation of Liberty DoLS legislation. The project contained details of mandatory training modules to cover Consent, MCA and DoLS and teaching undertaken on the 'Intensive Support Week'. The project was expected to be completed by mid-2016. The project had not been completed at the time of our inspection.
- The 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were kept at the front of the patients medical notes, allowing easy access in an emergency and were recorded on a standard form with a red border. All of the DNACPR orders were easy to read.
- We looked at 25 DNACPR forms at Glenfield Hospital and found there were inconsistencies in how these forms had been completed.
- Out of 25 DNACPR forms we looked at only nine were completed correctly (38%).
- DNACPR orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families, community DNACPR orders dated 2013 and lack of discussion with the patient.
- Of the nine not completed accurately, two of them had been discussed with the patient. Where the reason was given for not discussing with the patient was confusion or dementia, none of these DNACPR orders had a mental capacity assessment undertaken.
- We looked at the trusts Do Not Attempt Cardiopulmonary Resuscitation Policy. The policy states 'The trust had a legal duty to consult with and inform patients if a DNACPR order is placed in their notes (and relevant others if the person lacks capacity to be involved in the process)'.
- This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not being followed.
- The trust did not routinely audit DNACPR forms but told us this was being considered as part of the 'last days audit' for deaths in 2016.
- We discussed our findings with the safeguarding lead for the trust, who agreed there was a need for staff training on undertaking mental capacity assessments.

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Are end of life care services caring?

Good



We rated the caring of end of life care services at Glenfield Hospital as good because:

- Staff cared for patients with dignity and respect. Staff were seen to be compassionate.
- Patients we spoke with told us that staff were caring and looked after them well.
- A bereavement service was offered on site, with staff available to support family members with emotional support following bereavement.

Compassionate care

- We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), that staff spoke about the patients they cared for with compassion, dignity and respect.
- During our inspection, we observed patients being treated with compassion, dignity and respect. An example of this was a patient's family were allowed to bring the patient's dog in everyday to see them and sit on the bed for a few hours. The patient was in a side room.
- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- The two porters we spoke to told us the deceased were treated respectfully by ward staff.
- Services provided in the mortuary demonstrated respect and understanding of a patient's cultural or religious needs an example of this was the trust's urgent release policy, this was when the deceased was released within 24 hours of death and was used regularly with regard to cultural and religious beliefs.

Understanding and involvement of patients and those close to them

- We saw staff discuss care issues with patients and relatives where possible and these were generally clearly documented in patient's notes. An example of

this was on one of the wards we inspected, we saw a doctor explain to a patient and their relatives some of the side effects of their medication. This was done in a clear and concise way and in plain English

Emotional support

- The chaplaincy service held communion at the patient's bedside if patients were too ill to attend the chapel. The chaplain told us they conducted last rites and blessed the deceased in the mortuary as required.
- The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress. There were a number of thank you cards in the multi-faith chapel thanking the staff for their support during times of bereavement.
- The clinical nurse specialists (CNS) from the specialist palliative care team spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The team acknowledged the importance of supporting not only the patient but their relatives and friends throughout the dying process.
- Chaplaincy, bereavement and mortuary staff demonstrated empathy for the relatives and friends of the deceased, stating the need for a holistic approach to the emotional needs of those left behind.

Are end of life care services responsive?

Good



We rated the responsiveness of end of life care services at Glenfield Hospital as good because:

We found:

- Patients who were referred to the specialist palliative care team (SPCT) were seen according to their needs.
- The specialist palliative care team (SPCT) were committed to ensuring that patients receiving end of life care services had a positive experience.
- The referral data provided by the trust demonstrated that specialist care was being provided for patients with other life shortening conditions with 26% of patients seen not having cancer.

End of life care

- There were process in place for the reporting, management, response and learning from complaints.

However:

- Patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. This was not always possible and was dependent upon the patient capacity on the wards.
- There was no specialist end of life care pathway for patients living with a learning disability or Dementia.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team had established links with community palliative care services and the local hospice. Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care.
- Referrals to the specialist palliative care team for the period April 14 to March 15 were 1571 cancer and 435 non cancer. As a percentage this equates to 78% cancer and 22% non-cancer. total referral 2006 for this period
- For the period April 2015 to March 2016 to total referrals for cancer patients were 1672 and for non-cancer patients it was 600. As a percentage, this equates to 74% and 26%.
- Data showed that for the period 2014/15 98% of patients were seen within 24 hours of referral to the specialist palliative care team.
- The trust had a rapid discharge home to die pathway which could be facilitated within four hours. . However, this was not audited so the trust was not able to monitor its own performance.
- Ward staff said the specialist palliative care team normally responded within 24 hours to referrals.

Meeting people's individual needs

- There were no dedicated palliative care beds at this hospital. Patients identified as being in the last days or hours of life were mostly nursed on general medical and surgical wards. Nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. This was not always possible and was dependent upon the patient capacity on the wards.

- The trust had introduced the blue butterfly initiative. This is where a blue butterfly was placed on the side room door of a person who is at their end of life and remains on the door when they have passed over. The picture of the blue butterfly is on a number of different features, for example, when someone dies, the loved ones are given a booklet from the bereavement service, with a blue butterfly picture on called 'Helpful, information following a death'. The blue butterfly picture is also part of the individualised end of life care plan.
- Blue butterfly bereavement cards were sent to families and loved ones; these were hand written by the staff who had taken care of the patient. They had contact details on them if families wanted get in touch with the bereavement follow up service nurse.
- Nurses told us, if there was an end of life care patient, then visiting hours were not observed and families could stay for as long as they wished and all through the night.
- The mortuary had a viewing suite where families could visit their relatives and loved ones. We visited the area and saw the viewing suite was divided into a waiting room and a viewing room.
- The mortuary accommodated all faiths and worked closely with Muslim and Jewish undertakers to ensure deceased patients were cared for following their cultural and religious requirements.
- There were no facilities available for the bereaved to wash the deceased. The mortuary manager told us that by agreement, all ablutions of the deceased were carried out in the community.
- The mortuary had an 'urgent release policy', when the deceased is released within 24 hours and was used regularly with regard to cultural and religious beliefs.
- The mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious, spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- information was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen.
- There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life. These were also available in different languages other than English.

End of life care

- There were advice leaflets for relatives related to the withdrawal of treatment in the intensive care unit. The leaflet included information about the symptoms which might occur during the final stages of life.
- The chaplaincy team, which included 80 volunteers, visited the wards every day and visited all those patients who had been placed on the individualised end of life care plan.
- Within the chapel, there were separate prayer rooms with prayer mats and washing facilities for Muslim prayer.
- There were separate prayer rooms for other faiths such as Sikhs and Buddhists.
- The service employed 80 volunteers who would sit with end of life care patients as required. In January 2016, the trust had employed the first non-religious chaplain.
- As part of the individualised care plan there was a booklet called 'Information for relatives and friends'. The booklet explained in plain English what to expect when someone close to you is very ill, such as medication, changes that occur before death and the last days of the care plan.
- We saw leaflets for relatives with regards to the withdrawal of treatment in intensive care. There were leaflets in both the bereavement office and the mortuary concerned with help for the bereaved and what actions to take when someone dies.
- There were leaflets on the trust website about the bereavement service. They advised how to arrange a funeral, what to do when your baby has died, information on the chaplaincy service and what to do after the funeral. Information on the hospital accommodation for relatives was also available.
- There was no specialist end of life care pathway for patients living with a learning disability; however, the SPCT told us they would involve the learning disability team if required for both patients and family members.
- The trust although did not have a specialist end of life care dementia pathway, however they told us there was palliative care representation at the dementia implementation group.
- The 'Last days of life' booklet had been adapted for intensive care patients, for example, what to expect if the patient is on a ventilator in the last days and hours of life.
- Bereavement support was offered to relatives (adult inpatient deaths), aiming for contact six to eight weeks post-bereavement. Documentation showed that

between January and March 2016 49% of relatives took up the offer of bereavement support. Feedback from 104 relatives in March 2016 rated the quality of care as good to excellent for the majority 82%. 11% of relatives rated the care as 'ok', with 4% rating the care as 'poor'. 3% of relatives stated they were 'unable to say'.

- The trust used a translation service when required for those patients who could not speak English or English was not their first language. This was either undertaken face to face or a phone line could be used at the bedside

Access and flow

- The service had a patient register that trust staff could access via the trust's centralised, electronic patient co-ordination system; however, there was no electronic flagging system for end of life care patients on admission. This meant, the specialist palliative care team were reliant on staff to refer end of life care patients to them.
- Referrals to the specialist palliative care team could be made at any time from the patient's diagnosis. This meant the specialist palliative care team could be involved in the patient's care at an early stage. Audit results demonstrated 98% of patients had been seen within 24 hours of a referral being made to the specialist palliative care team.
- The specialist palliative care team (SPCT) had established links with community palliative care services and the local hospice. Staff told us this promoted shared learning and expertise and facilitated consistent care for patients who transitioned between services. Patients had timely access to the specialist palliative care team. Data showed between April 2015 and March 2016 they had 600 contacts, 983 of these were new referrals.
- The specialist palliative care team (SPCT) worked closely with the specialist discharge team to discharge people to their preferred place of dying if they were not on the rapid discharge plan.
- The Specialist Palliative Care Team (SPCT) had undertaken a review of 30 patients who were part of their caseload at the time of death or within 30 days of death in January and February 2016. The results showed that 83% of patients, who identified their preferred place of death, were supported to die there. Where this had not been achieved, it was due to the patients being assessed as too unwell to transfer home.

End of life care

- The review had four recommendations which included recommending that that earlier discussion of preferred place of death should be undertaken with patients referred to the Specialist Palliative Care Team, patients should be offered the opportunity to discuss their preferred place of death, staff needed to identify persons important to the patient who they would want involved in discussions about their care if they cannot be involved in this.
- The SPCT were fully aware of the outcomes of the review and were undertaking the recommended actions.
- Ward staff told us the specialist palliative care team would attend the ward if requested to supply advice and assistance.
- The specialist palliative care team undertook rapid end of life care discharges for patients who wished to return to the community or a 24 hour care facility. Staff told us rapid discharges could take place within four hours. Rapid discharges are normally undertaken for patients who have rapidly deteriorating condition, which may be entering a terminal phase. The specialist palliative care team gave us a recent example of a rapid discharge home for a patient that was achieved within four hours.

Learning from complaints and concerns

- For the period 2015 to 2016, the trust had received eight complaints relating to end of life services. One of these complaints related to Glenfield Hospital.
- The clinical lead would investigate formal complaints relating to end of life care and palliative care patients.
- Staff we spoke with told us if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.
- The specialist palliative care team told us all complaints about the service would be reviewed and actions would be taken and lessons learnt for the future.
- An example of this was a complaint about a patient transfer of care to the local hospice. The patient was referred by the specialist palliative care team but deteriorated and died before the transfer. The complaint was discussed at the end of life care board. As a result of the learning from this complaints, a leaflet was produced in conjunction with the hospice explaining about the process of transfers. We were told the leaflet was now given to all end of life care patients who

request a transfer. The leaflet stated the reasons for transfers and reasons why it may not be possible, for example if a patient requires oxygen or if there are not sufficient beds at the hospice.

Are end of life care services well-led?

Requires improvement



We rated the end of life care services at Glenfield Hospital as requires improvement for being well led because:

The leadership, governance and culture did not always support the delivery of high quality person-centred care.

- The leadership, governance and culture did not always support the delivery of high quality person-centred care.
- The trust does not have a fully developed end of life care strategy that included prioritised, time bound actions with appropriately allocated leads.
- End of life care services were discussed at board level. However, there was no executive or non-executive director appointed to provide representation of end-of-life care at board level.

However;

- Ward staff told us the specialist palliative care team were very supportive, approachable they were and how willing to help staff to provide the best care for the patients.

Vision and strategy for this service

- The trust did not have a fully developed end of life care strategy that included prioritised time bound actions with appropriately allocated leads.
- We asked the trust for its policy and strategy on end of life care. We were told the trust had developed guidance for the care of patients in the last days of life and this was updated following publication of NICE guidance in December 2015. We saw the trust had incorporated guidance on the five priorities for care of the dying person.

Governance, risk management and quality measurement

- The trust did not have a risk register specifically for recording end of life care as an area of concern. Instead the service used the trust's general risk register.

End of life care

However, information received from the trust showed there were three incidents raised in 2015 concerning the lack of the correct syringe drivers, but there did not appear to have been any actions undertaken and this was not identified on the trusts overall risk register.

- The specialist palliative care team had regular team meetings in which issues and general communications were discussed. For example staffing levels at the weekends and the teaching that was being undertaken
- We saw the action notes of the executive quality board for April 2016 which discussed the national report for England 2016 End of Life Care Audit – Dying in Hospital. The audit showed that when compared to other trusts in England; the United Hospitals Leicester consistently ranked in the bottom 20 for two of the five clinical indicators and was classified in the bottom ten compared with the national average for England. It was accepted the trust recognised dying later and the interval between recognition of dying and death was shorter.
- In almost all areas of the case note review undertaken within the trust it was agreed that when determining why discussions did not take place, there was a higher incidence of ‘no reason recorded’ documented for UHL than nationally, therefore suggesting documentation of end of life issues was poor and required improvement.
- In response to the audit, the trust had an interim at the end of life plan which had since been reviewed to improve usability. However, we could not see an end of life care strategy that included prioritised, time bound actions with appropriately allocated leads.
- The specialist palliative care team leads had started attending other speciality mortality and morbidity meetings to identify if there were any end of life care issues which still needed to be addressed.
- The specialist palliative care team had commenced conducting self-audits in response to the results of the national Care of the Dying audit to monitor their own improvement. There were some gaps in the audits being undertaken, for example auditing the numbers of patients who received a rapid discharge.

Leadership of service

- End of life was part of the cancer, haematology, urology, gastroenterology and general surgery (CHUGGS) clinical management group. The end of life care service lead was a palliative medicine consultant was also the deputy clinical director for CHUGGS.

- The specialist palliative care team said they were aware of the leadership structures and received good leadership and support from their immediate line managers.
- The specialist palliative care team confirmed there were regular formal information relaying processes including messages from the chief executive and board of directors, such as monthly e-mails.
- Nursing staff we spoke with on the wards, were able to name the specialist palliative care team nurses and gave us examples of cases where they had felt involved with improving care for patients who were at the end of life.
- Ward staff told us the specialist palliative care team were very supportive, approachable and they were willing to help staff to provide the best care for the patients.
- Staff were able to give examples of several support services available to deliver good end of life care and gave examples of patients being transferred to the local hospice and working closely with social services.
- The trust had an agreement with the hospice to ensure end of life care support was available 24 hours a day.

Culture within the service

- Staff within the specialist palliative care team spoke positively about the service they provided for patients and were passionate about their work.
- Ward staff were positive about the support provided by the specialist palliative care team.
- Staff reported positive working relationships, and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- There was good team working between the specialist palliative care team the bereavement service and the chaplaincy service.
- Most staff we spoke to said they felt confident to whistle blow or raise concerns with their managers.
- Staff said they had regular staff meetings where concerns were raised and discussed. We also saw documentation from the trust which showed this.

Public engagement

- We saw that patients experience stories were discussed at the board of directors meeting.
- There were no specific consultation groups in place for patients and the public to contribute to the development of end of life care services in the trust.

End of life care

- The chaplaincy service had recruited 80 volunteers of differing faiths who worked with patients and their families throughout the three hospital sites.
- Bereavement support was offered to relatives (adult inpatient deaths), aiming for contact six to eight weeks post-bereavement. Documentation showed that between January and March 2016 49% of relatives took up the offer of bereavement support. Feedback from 104 relatives in March 2016 rated the quality of care as good to excellent for the majority 82%. 11% of relatives rated the care as 'ok', with 4% rating the care as 'poor'. 3% of relatives stated they were 'unable to say'.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.
- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers.
- There was a process in place to feedback information to staff via newsletters, emails and staff meetings. Staff were informed about the outcome of complaints and incidents within their area of practice.
- The chaplain was part of the multi-disciplinary team who worked in end of life care and supported patients, families and staff as required.
- Most wards had a designated end of life 'champion' in place with responsibility for promoting the use of the end of life AMBER care bundle when this was appropriate.
- The mortuary no longer contributed directly to the EOLC policy; however they did provide input for the last offices policy.

Innovation, improvement and sustainability

- The trust had recruited a bereavement nurse specialist in December 2015 who worked across the three hospital sites and closely with the specialist palliative care team (SPCT).
- The trust participated in the Transforming End of Life Care in the Acute Hospitals programme. The transform programme aimed to improve the quality of end of life care within acute hospitals across England. It focuses on both the quality of care provided by acute hospitals, as well as the role acute hospitals have that provide care for people who are approaching end of life.

Staff engagement

Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

University Hospitals Leicester (UHL) was the seventh largest provider of outpatient department (OPD) appointments in England from September 2014 to August 2015. Leicester Royal Infirmary (LRI) specialities see 58% of total outpatient attendances, whilst Leicester General Hospital (LGH) and Glenfield Hospitals (GH) see 25.5% and 16.7% respectively. The remainder of outpatient appointments are held in the trust's smaller outlying hospitals in Leicestershire and Rutland towns.

Outpatient services at Glenfield Hospital had 148,119 attendances between April 2015 and March 2016 (first and follow-up appointments).

During our inspection of Glenfield Hospital we visited the following clinics: breast care; cardiac and respiratory rehabilitation; cardiology; orthodontics and restorative dentistry; We spoke with 14 patients, 3 clinicians, 6 nurses 1 healthcare assistant and a physiotherapist.

Outpatients specialities were managed by different clinical management groups (directorates). For example, cancer, palliative care, urology, gastrointestinal, and general surgery were in the Cancer, Haematology, Urology, Gastro intestinal and General Surgery (CHUGGS) clinical management group; Ophthalmology, Orthopaedics, Plastics, Breast Care, Maxillofacial, oral surgery, and ENT reported to the Musculoskeletal and Specialist Surgery (MSK) clinical management group .

The Clinical Support and Imaging clinical management group (CSI) had responsibility for diagnostic imaging, including X-rays, magnetic resonance imaging (MRI) scans and CT scans, medical records management and the booking centre.

Outpatients and diagnostic imaging

Summary of findings

Overall we rated Glenfield Hospital Outpatient and Diagnostic Imaging services as requires improvement.

We found that:

- There were outpatient delays and cancellations across the trust. Some people were not able to access services for assessment, diagnosis and treatment when they needed to. The trust recognised this but arrangements to match future capacity to demand were not in place. Governance arrangements for better waiting list management were in development
- Some arrangements lacked controls to keep patients safe. Fridge temperatures for medicines were not safely monitored but this was rectified during our inspection.
- There was no audit process or record of the use of some FP10 prescription pads, which was a risk that the prescription issuing process could be abused.
- The trust had not implemented and audited use of the WHO safety checklist across the trust.
- Patient dignity was compromised in some areas. Some reception arrangements, for example diagnostic imaging reception, were not conducive to privacy or confidentiality. The 'shuttle walk' test, which formed part of the cardiac rehabilitation programme, was not performed in a location that respected dignity or privacy of patients.
- Leadership for outpatient services was fragmented. Risks, issues and poor performance were not always dealt with appropriately or in a timely way, and this meant patients sometimes had long waits for new or follow up appointments and experienced in-clinic delays.
- However, staff understood and fulfilled their responsibilities to raise safety concerns and report incidents and near misses; managers supported them when they did. If something went wrong, there was a thorough review or investigation involving all relevant staff and people who used services. Lessons were learned and communicated widely. Equipment checks were up to date and clinical areas were clean

on the day we inspected. Staff had a good knowledge of safeguarding and the Mental Capacity Act or knew who they could go to for expertise. They knew what to do if a patient's health started to deteriorate.

- Diagnostic imaging services learned from incidents and improved safety. They used diagnostic reference levels to check dosages and had a range of safety related policies which staff understood and used. Imaging services were available seven days a week. GPs could refer patients to Glenfield for diagnostic imaging procedures with a 48 hour turnaround.
- Patients, those who were close to them and stakeholders gave positive feedback about the way staff treated people. Glenfield based specialties had high 'would recommend' scores from patients. Patients we spoke with were happy with their care and spoke highly of staff at Glenfield hospital.
- Care was planned and delivered in line with current evidence-based guidance. Examples of good practice included the Rapid Access Heart Failure Clinic. The services used local and national audit arrangements to maintain the effectiveness of treatment. Clinicians worked effectively in multidisciplinary teams to find solutions for complex patients. There were one-stop clinics in breast care and a pulmonary embolism ambulatory clinic. This meant patients could discuss a range of related issues on the same visit to the hospital. There was a positive working culture at Glenfield, and innovative practices, particularly in cardiac and respiratory rehabilitation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



We rated the service as good for safe.

We found:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; managers supported them when they did. If something went wrong, there was a thorough review or investigation involving all relevant staff and people who used services. Lessons were learned and communicated widely.
- Equipment checks were up to date and clinical areas were clean on the day we inspected.
- Staffing levels were sufficient for clinic needs. Staff had a good knowledge of safeguarding or knew who they could go to for expertise. They knew what to do if a patient's health started to deteriorate.

However, we also found:

- There was no consistency in monitoring fridge temperatures for safe medicines management. However this was addressed during our time at the trust.
- There was no audit process or record for the use of some FP10 prescription pads, which meant there was a risk that the prescription issuing process could be abused.
- Implementing the duty of candour training and the use of the five safer steps for surgery checklist was in the early stages.
- The outpatient service did not have quality or safety information on performance tables (dashboards) reported to managers or displayed publicly.

Incidents

- Glenfield Hospital reported no never events in outpatients or diagnostic services between May 2015 and April 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- Diagnostic imaging had one serious incident between July 2015 and June 2016. The error resulted in a delay in treating cancer when a mass identified on a scan had been overlooked. As a result, the diagnostic imaging service learned to be proactive about acting on results. Staff set up a procedure to inform referring clinicians as soon as they noticed any abnormalities on their patient's scan.
- There was a culture of openness within the diagnostic imaging department. Between March 2015 and April 2016 the clinical management group (CMG) responsible for imaging, reported 796 incidents trust-wide, most of which were concerned with imaging. The trust did not give us site-specific information, so we cannot report on how many of these came from Glenfield Hospital.
- Staff told us they reported every sort of incident but especially for radiation protection. Managers received an up to date report of incidents. The service transferred its learning to the other two Leicester hospital sites through meetings and on-line alerts. There were staff leads for different types of imaging, such as CT, MRI for example. These staff leads ensured their teams knew about the incidents and learned from them.
- The cardiology service told us about incidents they learned from. For example, a fall which happened in their clinic. This resulted in changes to their cleaning arrangements. Some of the incidents they told us about happened elsewhere in the trust, showing that the learning was transferred between sites. Staff discussed incidents at team meetings and received safety updates in emails. Staff at all levels told us that incidents were discussed and learning shared.
- Orthodontics and Radiology recorded an incident regarding lost patient notes. In response they investigated and learned lessons from the event.
- In outpatient specialities, a quality and safety lead staff member attended the board meeting where incidents and complaints were discussed. Incidents, complaints and related actions were discussed at mortality and morbidity meetings quarterly. In between meetings, doctors were kept informed by email.
- Diagnostic imaging staff at Glenfield had a 'safety huddle' every morning at 8:30 am. They shared any equipment or staffing issues and protocols. Staff had regular briefings with management to keep them updated.

Outpatients and diagnostic imaging

- Staff received feedback if they reported an incident. They reported them onto the electronic incident reporting system. They were able to see that their manager dealt with their incident and invited them to speak with her for further feedback.
- The diagnostic imaging department had a departmental radiation protection notice board. This displayed charts referring to Ionising Radiation (Medical Exposure) Regulations IR(ME)R compliance audits such as the patient identity audit and the date of the last menstrual period to avoid x-raying a foetus along with dose reference levels, and personal protective equipment audit results.
- Outpatient services lacked dashboards which reported transparently on quality, safety, and patient satisfaction levels. We saw some patient satisfaction information on clinic noticeboards but no comprehensive quality or safety monitoring reporting.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.' We saw from incident investigations that incident investigators involved patients and their families through the investigation process.
- Knowledge about the duty of candour was not embedded. Staff were aware of it, but it was an informal understanding. Staff in outpatient clinics and in diagnostic imaging services explained to us what the duty of candour was. They said they were open and honest about mistakes, but could not remember a specific time when they used the duty. They had not had any specific training and the trust did not audit the effectiveness of training or understanding of the duty.
- A cleaning audit was displayed in the thoracic medicine/ respiratory clinic. This showed cleaning reached 92% but it did not show the month, so it did not assure us that the hospital audited cleaning regularly.
- The breast care service had cleaning rotas for every clinic room. These were up to date. The female toilets, clinic and waiting environment were visibly clean.
- The diagnostic imaging environment was clean, with up to date cleaning records. Hand washing results showed 80 – 100% compliance.
- We observed radiographers using hand gel before and after contact with patients. They were 'bare below the elbows' and wore the correct uniform.
- The Infection Control team told us they concentrated their audits on ward in-patient areas where there was the greater risk of healthcare associated infection. The team did not cover outpatient clinics.
- The trust did not routinely audit hand hygiene for outpatient clinics. The cardiac investigations hand hygiene audit result showed 88% compliance for May 2016. However, we did not see results of audits on display in a place where patients could see them, anywhere in the hospital. trust.
- The service ensured that personal protective equipment was used, including gloves and aprons. We observed diagnostic imaging staff using appropriate protective equipment including lead aprons.
- Wound drains were occasionally removed in the breast care clinics but this was usually done on a surgical ward. The breast care clinic had appropriate personal protective equipment such as visor masks to protect nurses and doctors faces. This meant that staff could carry out the procedure safely if needed.

Environment and equipment

Cleanliness, infection control and hygiene

- Outpatient clinics were generally cleaned at the end of a cleaner's shift. Staff told us that cleaners did the wards first and then cleaned clinics in the remaining time before 8pm. Local leaders wanted the cleaners to clean in the morning before clinics, so they were clean for patients. However, the clinics were visibly clean when we inspected.
- Staff told us they were able to get more thorough cleaning done just before our inspection, for example cleaning under desks.
- Staff ensured that equipment checks were up to date. In the asthma and cardiac clinics we checked the adult resuscitation trolleys which were correctly stocked and daily checks were completed in full.
- There was a checklist for a specific box containing equipment to respond to any patients with hypoglycaemia (low blood sugar) and a nebuliser.
- In the breast care clinic, the resuscitation trolley was correctly secured and its stock up to date. Equipment had labels on to show it had been tested regularly, for example the glucometer was correctly checked and up to date.

Outpatients and diagnostic imaging

- There was a sepsis tray at the bottom of the resuscitation trolley which contained bottles for taking blood cultures, the sepsis protocol and six steps checklist. Resuscitation trolleys we checked in diagnostic imaging had up to date stock and staff checked them daily.
- The maintenance of equipment kept people safe. The managed equipment leasing arrangements for diagnostic imaging equipment ensured equipment was up to date. This was because the supplier automatically replaced ageing equipment with new machines.
- Warning lights flashed outside diagnostic imaging rooms where x-rays were taking place, such as the clinical decisions unit x-ray room, and there were security locks on the doors. All the warning lights were in good working order.
- Orthodontics facilities were conducive to safety. There were six treatment rooms, one of which was used for decontamination of dental equipment. There was a dental laboratory with four technicians. The service has its own x-ray and CT scanning area which was clean and staffed by two specialist radiographers.
- Arrangements for managing waste kept people safe, sharps were disposed of correctly and domestic and clinical waste were disposed of separately.

Medicines

- In clinic D at Glenfield Hospital, medicines were kept locked in cupboards. Only registered nurses knew the code to access the medicines.
- FP10 prescriptions are those used by doctors, dentists or nurse prescribers for a patient to take to a pharmacist in the community. One locked cupboard in Clinic B, the asthma clinic, contained FP10 prescriptions but there was no audit trail for their use. This meant there was a risk of prescriptions being used illegally.
- In the breast care clinic, medicines were stored correctly in locked cupboards in a locked room. There were no controlled or pain relief drugs in the clinic. If patients needed pain relief, a doctor would prescribe it and the service would fetch it from the pharmacy. Prescription pads were under lock and key and we saw the audit trail.
- Drug boxes in diagnostic imaging were in date and stored safely. All medicines cupboards were locked.
- We identified fridge temperatures were not recorded correctly; single daily temperatures were recorded rather than maximum and minimum levels. This did not

demonstrate a consistent temperature had been maintained to assure the safety and efficacy of the medicines. Action was taken at the time of the visit to address deficiencies in monitoring (and confirmed in place on unannounced visits).

Records

- The hospital generated monthly reports to track when notes arrived too late for a patient appointment. These statistics were reported at clinical management group assurance meetings. They were not segmented by type of hospital activity, so management were unaware of how they affected outpatients specifically.
- The percentage of late notes trust wide varied between 3.7 and 5.3% for April 2015 to March 2016. We did not have a breakdown of notes arriving late for clinics specifically at Glenfield Hospital.
- Specialties cancelled approximately 10% of requests for notes, showing that they cancelled bookings and re-arranged appointments.
- Patient's records were locked away safely. For example, at clinic D we saw two locked notes trolleys positioned in the corridor.
- Delays in sending letters to patients and GPs after consultants appointments was a risk. The corporate risk register identified this as a moderate risk to patient safety and experience. The service had a plan to mitigate the risk which included recruitment and training. In addition, it had a prioritised approach to reducing the risk presented by the x-ray reporting backlog of 10274 images, dating from 2015.

Safeguarding

- Clinics did not necessarily receive an alert about high risk patients before the appointment took place. This meant services could not prepare in advance for vulnerable patients. Staff in outpatient clinics were aware they might be the first to identify people at risk. They told us they would tell the senior nurse on duty and inform the safeguarding team, and ensure the patient's needs were reflected on their records.
- We spoke to nurses and imaging staff who had a good awareness of protecting vulnerable adults, including spotting the signs of domestic violence and protecting children. They could give us examples of when they had applied this. Staff received safeguarding training by e-learning. We saw the trust's data which showed that 97% of qualified and unqualified nurses in outpatient

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clinics had up to date adult safeguarding training and either level one or two for safeguarding children. Staff were aware of their responsibilities and would escalate any concern to their line manager and the safeguarding team.

- The diagnostic imaging service at Glenfield Hospital were aware of safeguarding issues. Staff accompanied patients on their way to and from a scan. Nurses were on hand to help with vulnerable people at the clinical decisions unit where most of the scanning took place.

Mandatory training

- Almost all diagnostic imaging staff (98%) were up to date with their radiation protection training. The diagnostic imaging service had a staff record training database which stored up to date records of staff training on Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) e-learning, Ionising Radiations Regulations (IRR 99) e-learning and compliance with equipment training. Training records were comprehensive and accessible.
- Training participation in most clinical management groups within outpatient clinics was between 90% and 100%. The trust's target was 95% compliance. Exceptions were training completion rates for consent, Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007) where 67% of qualified nurses in specialist medicine complied and non-qualified nurses in cardiac and gynaecology were 83% and 88% compliant respectively.
- In specialist medicine, 83% of qualified nurses completed basic life support training and conflict resolution training. This meant not all staff were trained on key areas, and there was scope to improve training compliance, particularly for consent, Mental Capacity Act and Deprivation of Liberty Safeguards training. The trust did not monitor training by hospital site or by overall attendance to all mandatory training topics.

Assessing and responding to patient risk

- The hospital had not fully implemented World Health Organisation (WHO) safe surgical procedures in outpatients when we inspected. Clinicians performed minor operations in orthopaedics and restorative dentistry and used an adapted version of the five steps to safer surgery. The trust had not audited the use of the document for compliance.

- There was a procedure in place to ensure that patients received the right radiological scan at the right time. This included identity checks (name, address, date of birth) at reception and before scanning. Before scanning, staff carried out checks to ascertain the correct side of the body, which area to be scanned, the patient's scanning history and their pregnancy status.
- The clinical support and imaging risk register included risks such as the age of equipment resulting in suboptimal radiotherapy treatment; the risk of the backlog of unreported CT and MRI images leading to a clinical incident and insufficient staffing in ultrasound.
- Nurses and clinicians responded well to changing risks. For example, all cardiology staff had training in advanced life support, and ready access to a resuscitation trolley and defibrillator. The training information we received from the trust was not site specific but 90% of nursing staff had recent basic life support training. All rapid access clinic staff had basic or advanced life support training and knew about how to react to patients who may have a sepsis. Sepsis is a potentially life-threatening condition, triggered by an infection or injury. They would also complete appropriate documentation to record vital signs, for example pulse and blood pressure. All staff carried pocket cards reminding them of the steps to take if sepsis was suspected.
- Breast care staff knew how to respond to changing risks. Processes were in place and staff knew how to respond appropriately if a patient deteriorated.
- Orthodontics staff had received basic life support training and could explain what they would do if a patient deteriorated. Staff told us that they would access help from elsewhere quickly.
- Diagnostic imaging staff knew what to do if a patient deteriorated and processes were in place to reduce risks to patients. They also knew when to alert security staff
- The diagnostics imaging service had an escalation policy in case it did not meet its own targets for patients requiring scans. For example, there was a two day target for scans requested by the emergency department, one week for an in-patient and three weeks for an out-patient. It recorded x-ray plain film turnaround for the emergency department against a 30 minute target. This meant senior leaders could take action on any risk of delay to patients. When we inspected the service completed 94.2% of x-rays within 30 minutes, just short of the standard of 95%.

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- The Imaging service had a range of local policies to minimise risk. These included procedures for identifying patients correctly and minimising unintended radiation doses. The service also had a policy for identifying referral practitioners which was approved in March 2015. This allowed nurses, allied health professionals and health care scientist to request x-rays under delegated arrangements, if they received the relevant training.

Nursing staffing

- We did not observe any staff shortages at Glenfield Hospital. Clinical specialties assessed the needs of each individual clinic with the speciality to determine the level of nursing support needed, based on their technical needs and complexity of case mix. There was no specific tool for this.
- Each outpatient clinic had a trained nurse to deal with any situation that might arise, for example, patient collapse, patient becoming unwell and needing extra-support such as oxygen.
- Nursing staff and care assistants in outpatients rotated across all three hospital sites. Some people at Glenfield Hospital had worked there for a long time and felt very much based where they worked and preferred to stay there. Staff were employed to work cross site to accommodate service need; however every effort was made to base staff on the hospital site that they prefer 98% of the time with the exception to cover sickness, annual leave and service needs.
- Services at Glenfield Hospital used some bank nurses to cover shifts. Trust data showed that in March 2016 there were 12.1 bank/agency nurses in breast care, 3.4 in nuclear medicine and 26 in other outpatient clinics.
- Average monthly nursing bank usage in outpatients at Glenfield Hospital was low at 0.3%. At the other Leicester hospitals it was 1.1%
- The clinical support and imaging clinical management group (CSI) supplied registered nurses, health care assistants and plaster technicians to the OP services that they were responsible for. CSI estimated that there was a vacancy for 0.8 wte of a band 5 nurse at Glenfield Hospital. The clinic coordinators and administrative team leaders were managed and supplied by the other CMG's/ specialties that provided the OP service.
- Cardiac rehabilitation staff rotated across all of the trust's sites and felt up to date with what was happening at each site.

Medical staffing

- The diagnostic imaging service told us they did not have enough radiologists. In response, they had successfully recruited 11 imaging consultants to start in September 2016. There were 50 diagnostic imaging vacancies though these were mainly for ultrasound and computerised tomography procedures. The service had tried to recruit to ultrasound management jobs with some success but this was still continuing when we inspected. In diagnostic imaging a shift rota was in place to ensure adequate cover for nights and weekends. Staff told us they agreed the shift pattern with managers and it was acceptable to them.
- Medical staffing was not aligned to need. We saw no assessment of patient demand by speciality. Nursing staff could not tell us how many doctors there should be in each clinic. Sometimes patients turned up to a clinic with only one doctor attending which meant they would have to wait longer to see the doctor or book an appointment for another day.
- Respiratory medical staffing met the needs of patients. There were 19 respiratory consultants and 14 of these were full time equivalents. The service ran specialist respiratory clinics, lung clinics and rapid access clinics.
- Restorative dentistry/orthodontic clinics were consultant led (2 consultants). The trust was in the process of recruiting another consultant.
- The trust did not provide data on locum usage in all outpatient specialities.

Major incident awareness and training

- The trust had a business continuity management policy and clinical management groups had procedures and service incident response plans. As outpatient staff reported to different clinical management groups, their understanding of what to do in an emergency varied.
- Diagnostic imaging staff knew where to find the major incident folder and could give us a brief summary of what they would do if there was a major incident.
- The service had guidelines for a radiation or radioactive incident. These listed types of incident. Staff had to enter details on the electronic incident report system as soon as possible. There was a policy and procedure for reporting adverse events, which included what to do in the case of extreme events in and outside of normal working hours.

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- The service had flowcharts for staff to follow in case of accidental exposure to radiation due to equipment failure, and accidental spillage in nuclear medicine. They had an action plan in case of a radiation or radioactivity incident occurring.
- The trust's ionising radiation and medical exposure policies described arrangements at a high level. The trust had a procedure for reporting adverse incidents on its electronic incident reporting system. The nuclear medicine service had a quality management system which included contingency plans for spillages. This included prioritising injured people and decontamination arrangements; syringe failure and what to do in the event of a fire, theft or loss.
- Most outpatient staff saw their role as supporting the Leicester Royal Infirmary in a major incident response.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We have not rated the effectiveness of outpatient services.

However we found the following areas of good practice:

- Care was planned and delivered in line with current evidence-based guidance. Examples of good practice included the Rapid Access Heart Failure Clinic. The services used local and national audit arrangements to maintain the effectiveness of treatment. Diagnostic imaging used diagnostic reference levels to check dosage.
- The hospital had comprehensive pain management clinic arrangements.
- Staff were competent and encouraged to develop.
- Services reviewed complex cases in multidisciplinary teams, for example in breast care. There were one-stop clinics in breast care. This meant patients could discuss a range of related issues on the same visit to the hospital.
- Diagnostic imaging services were available seven days a week. GPs could refer patients to Glenfield for diagnostic imaging procedures with a 48 hour turnaround. Consultants communicated with other services and sent out letters quickly after appointments.

However, we also found:

- The services did not routinely ask if patients who were waiting were in any pain.

Evidence-based care and treatment

- The hospital based care on the National Institute for Health and Care Excellence guidelines. The Rapid Access Heart Failure Clinic (RAHFC) was started in University Hospitals Leicester as a response to NICE guidelines in October 2012. .
- The diagnostic imaging service at Glenfield met the NICE CG15 guidance for direct access for GPs which had a 48 hour turnaround time. This service was open on weekdays. This led to an increase in workload for magnetic resonance imaging scanning, and the service planned to train more radiographers in this.
- The diagnostic imaging service had an audit programme which complied with IR (ME)R guidance. They chose a different audit each month to review at Radiation Protection Board. They audited processes such as checking the patient's identity and the correct site on the patient's body. They also audited how well they worked with others. There was a radiology audit of appropriate use of the multidisciplinary team.
- Diagnostic imaging had a procedure for the use of local diagnostic reference levels (the dose set at the mean of a group of patient doses). This included gathering the data and establishing the level for patients within a weight tolerance, and displaying the data in the imaging control area. The service identified three cases trust wide where there was a difference with regional practice. Its practice was evidence based, and staff referred to an online database called I-refer for good practice.
- The imaging service had a comprehensive suite of policies. There were also protocols and proformas in clinics for staff to follow and refer to. For example, staff used proformas for pulmonary rehabilitation referrals and to record clinical data on heart failure, respiratory function and pulmonary rehabilitation. This ensured that they applied the same standards to each patient and helped with the collection of data to look at patient outcomes.
- Diagnostic imaging had a radiation safety policy which outlined all safety areas overseen by the Radiation Protection Committee and specified measures to keep doses to patients as low as reasonably possible and to minimise staff radiation exposures.

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- Radiation doses to staff were a concern for the trust. Staff wore radiation monitoring badges but replacement badges were difficult to find. The radiation protection service were concerned about lack of supply and administrative support. This meant they did not have a complete picture of radiation doses to staff. The main area of concern was radio pharmacy due to exposures to the finger.
- There was local guidance governing CT scanning at Glenfield Hospital. It explained access to controlled areas, arrangements for the protection of staff and public and contingency planning arrangements.
- The trust's Ionising Radiation (Medical Exposure) Regulations 2000 policy outlined its arrangements to meet Ionising Radiation (Medical Exposure) Regulations (IR(ME) R) regulations. It detailed roles and responsibilities, the need for clinical audit, correct maintenance of equipment, training and compliance arrangements to limit risk.
- Local Rules for minimising radiation exposure in line with the Ionising Radiations Regulations (IRR99) were displayed in the control room for staff to refer to if needed. These regulations require employers to keep exposure to ionising radiation as low as reasonably possible.
- The diagnostic imaging service had a GP open access service with a 48 hour turnaround time. It met the NICE CG15 guidance for direct access for GPs. This service was open on weekdays.

Nutrition and Hydration

- Clinics in the hospital had water fountains and food and drink vending machines available for patients.
- Staff offered food to patients who were waiting a long time for their appointments. For example, sandwich boxes were available for breast care patients if their appointment was delayed.

Pain relief

- There was a pain management team working at all three sites including Glenfield Hospital. It ran specialist clinics for children and those experiencing facial, pelvic and drug re-addiction pain. Complex pain management programmes were also offered. Their multidisciplinary team consisted of pain consultants, nurses, physiotherapists, occupational therapists and health care assistants

- Staff at clinics did not routinely ask patients if they were in any pain when they arrived, or used a pain assessment tool, but none of the patients we spoke with were in pain. Clinics stocked held paracetamol and could ask a doctor for a prescription if they found during consultation that patient needed a stronger form of pain relief.

Patient outcomes

- The Rapid Access Heart Failure Clinic (RAHFC) audit observed lower rates of subsequent hospitalisation with heart failure, and related bed occupancy via the RAHFC. Cardiology audited the impact of the rapid access heart failure clinic at UHL on subsequent heart failure admissions, bed occupancy, and mortality and reported their findings in June 2015. The only actions remaining concerned securing funding from clinical commissioning groups to continue the service.
- The orthodontics service used audits to improve services. The service undertook audits for children with genetic conditions. They evaluated patient notes in March 2015 and found that 75% of patients had a validated x-ray, meaning that 25% of x-rays were not evaluated.
- The diagnostic imaging service could demonstrate learning from audits. They completed audits such as the Quality Assurance of Screening CT Colonography for the Bowel Cancer Screening Program (BCSP); an audit of GP referrals for Ultrasound Ankle and Knee; Impact of fluorodeoxyglucose (FDG) PET-CT in gynaecological malignancy: a single institutional experience; accuracy of renal tract ultrasound in the detection of renal scarring compared to DMSA. These audits resulted in improvement actions, such as training on how to detect renal scarring for the renal tract ultrasound audit.
- In respiratory rehabilitation services staff monitored patients progress by using tools such as a cough and Nijmegen questionnaire. Patients used the Nijmegen questionnaire to score against different criteria such as chest pain, feeling tense and whether they were experiencing blurred vision. Staff collated the data to monitor patient outcomes and review their individual plan of care.
- The cardiac service was participating in a study as part of the National Centre for Sport and Exercise Medicine (NCSEM) programme to monitor cardiovascular accident (stroke) patients through an exercise programme. The NCSEM is a major Department

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of Health initiative to deliver education, research and clinical services from three hubs in the London (ISEH), East Midlands and Sheffield. The service was also setting up a heart failure web based programme to give additional support to heart failure patients. When we inspected it was too early to see the results.

- Diagnostic imaging services had not yet implemented the imaging services accreditation scheme (ISAS). ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. Services acquiring ISAS accreditation are required to work to specific standards. The annual plan showed that they intended to work on this accreditation in 2016/2017.

Competent staff

- The trust became aware of the lack of staff competency to administer outpatient's bookings to meet the 18 week waiting list target. It developed an e-learning module for the processes for the referral to treatment standard (waiting time of less than 18 weeks). It had not evaluated its effectiveness when we inspected.
- At Glenfield Hospital, 91% of outpatients and diagnostic imaging staff received appraisals, compared to 90% at Leicester Royal Infirmary and 94% at Leicester General Hospital. Staff told us their appraisals were useful and led to development.
- Managers in diagnostic imaging encouraged staff to develop. The imaging service operational meeting notes showed that the trust found additional funding for two radiographers to train in musculoskeletal magnetic resonance reporting and for two people to train in a computerised tomography Head course.
- Diagnostic imaging had a practice learning team. They aimed to develop assistant practitioners in radiography and to give students the best possible training. Student numbers increased over time and other trusts copied this practice.
- Two new radiographers explained to us that there was a good induction process in place with a period of observation/preceptorship, and always a more experienced radiographer on hand to ask, even at night. The departmental manager set learning targets to be achieved within certain timescales. This ensured staff kept on track with their learning objectives.

Multidisciplinary working

- Multidisciplinary teams reviewed complex cases to find the best solutions for patients. For example, an MDT met in breast care to formulate treatment plans for patients with malignant breast disease.
- There were one-stop clinics in breast care, transient ischaemic attack (minor stroke) and deep vein thrombosis (DVT). This meant patients could discuss a range of related issues on the same visit to the hospital.
- Cardiac rehabilitation services worked together for patients and took services out to the community, for example running sessions at the Polish Club in Melton Mowbray. Their MDT approach included physiotherapists, speech therapists, cardiologists, and therapist had in-service training on MDTs.
- The diagnostic imaging service re-audited its MDT approach following an incident where a patient's lung lesion was not identified at an MDT. This recommended that the duty radiologist at MDT should provide a MDT review on the imaging patient system to support the imaging report(s), document if there is a change in the interpretation of imaging and if the MDT outcome has implications for future imaging tests. The changes were in place but the hospital had not audited the process.

Seven-day services

- Diagnostic imaging at Glenfield was open during the day seven days a week and provided a seven day on-call night time service. There were magnetic resonance imaging and computerised tomography facilities which worked at full capacity. General practitioners (GP's) could refer patients for diagnostic imaging procedures with a 48 hour turnaround at Glenfield Hospital from 8:30 am to 4.30 pm, five days a week.
- Cardiac rehabilitation held some Saturday clinics which helped patients who worked during the week. The breast care clinic was open during weekday mornings and sometimes in the evening when there was high demand.
- The phlebotomy clinic for patients who required blood tests worked Monday to Friday 8am to 5:30 pm.
- The trust provided a pharmacy service across all three sites, which was available Monday to Friday and Saturday and Sunday mornings. An on-call service operated outside of these hours.

Access to information

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- The diagnostic imaging service provided electronic access to imaging results for other services in the hospital.
- Consultants told us they expected letters to patient GPs to be sent out after clinic within a few days for urgent biopsies and no more than 4 weeks for non-urgent matters
- Information technology (IT) was a constraint on productivity. Diagnostic imaging staff told us they had problems getting help if their IT equipment was faulty and it slowed down the imaging service.
- Outpatient clinic staff told us the patient information system was limited in its reporting function and how it could link with other hospital systems. It was not auditable and this meant that the Informatics team had to develop reports to check that outpatient data quality was correct.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinicians were trained in how to obtain consent or otherwise from patients who required an invasive procedure. For example, patients attending an orthodontics treatment planning session were given the opportunity to consider their options. When the patient returned, the clinician discussed the benefits and risks of the proposed treatments prior to gaining consent . The consent form included copies for the clinician and the patient.
- Consultants informed us that they would ask for consent with carers present or ask for those with lasting power of attorney for patients to sign the consent form.
- Staff in clinics (95% of non-qualified nurses and 97% of qualified nurses) had received training on Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There were local dementia champions who told us patients living with dementia were treated at the start of a clinic. Staff told us they knew where to locate a dementia champion if they had questions.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good.

We found:

- Patients,, those who were close to them and stakeholders gave positive feedback about the way staff treated people. Glenfield based specialties had high 'would recommend' scores from patients.
- Patients we spoke with were happy with their care. Staff treated them with respect and kindness and helped them to cope emotionally with their care and treatment.
- People's social needs were understood and services provided information about specific medical conditions.

However we also found:

- Some reception arrangements were not conducive to privacy or confidentiality and the 'shuttle walk' test, which formed part of the cardiac rehabilitation programme, was not performed in a location that respected dignity or privacy of patients.
- The clinic which patients attended to have blood specimens taken (phlebotomy) lacked privacy. There were three chairs located in a small area with no curtaining between the chairs.

Compassionate care

- We spoke with six patients in cardiology who all told us they were happy with the service. Patients in the breast care clinic said the service was 'amazing' and 'very helpful.'
- All four diagnostic imaging patients we spoke with were pleased with the care they received. They said staff were very caring and received clear appointment letters which arrived on time.
- The hospital carried out an electronic survey of outpatients care from September 2015 to February 2016. In February 2016, 290 patients completed the survey. Between 93% and 99% of patients responded positively to questions about their involvement in decisions about their own care and privacy and dignity.
- The trust gathered Friends and Family Test feedback for outpatient specialities between October 2015 and March 2016. The trust gathered this information by clinic and by site, and by speciality. The feedback showed that patients would recommend Glenfield based outpatient clinics for example 98% of patients would recommend breast care services, 99% would recommend cardiac rehabilitation and 97% would recommend respiratory medicine.

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- In the February 2016 electronic survey of outpatients and those close to them, 89% of friends and relatives (14 people) felt as involved as they wanted to be in their loved one's care and treatment. This increased to 94% in May 2016.
- We observed nurses, doctors and administrative staff being respectful, calm and considerate with patients. They were supportive and assisted patients either by lending physical support or by helping them to understand an issue.
- Staff understood and respected people's personal, cultural, social and religious needs. Clinicians allowed families to accompany patients to consultations and found a colleague of the same sex as the patient to carry out the consultation, if the patient preferred.
- Chaperones were available, and of the same sex where possible. Nurses routinely chaperoned patients in clinics, as a nurse was allocated to each consultant. However, we did not see any publicly displayed notices informing patients of their right to ask for a chaperone.
- Diagnostic imaging reception at Glenfield Hospital was not conducive to confidentiality. There were no signs asking queuing patients to stand behind a line to give patients at the desk some personal space. Although the receptionist deliberately spoke quietly, we could overhear details about patients.
- The clinic which patients attended to have blood specimens taken (phlebotomy) lacked privacy. There were three chairs located in a small area with no curtaining between the chairs.
- Arrangements for testing patient's exercise capacity were not dignified. Staff carried out the 'shuttle walk' test with patients in the middle of a general corridor in the hospital. Porters, other patients and staff also used the corridor constantly. In the previous two years, the services changed the location of this test twice but they were both in public areas. Staff informed patients about this before the test, so that they could refuse to do the test in a corridor if they wished to. Staff felt that a gym would be a more appropriate location but access to the gym was in demand and difficult to book at the right time. A shuttle walk test explores how far and fast a patient can walk (without stopping for a rest) by following a series of time signals. We spoke to a patient undergoing the test who informed us he had been concerned about the location of the test initially but once he had commenced he had forgotten about it.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so they understood their care, treatment and condition. We observed radiographers introducing themselves and informing patients about the procedure.
- Patients received copies of letters sent between the hospital and their general practitioner (GP). They told us the hospital gave them information about who to contact if they were worried about their condition or treatment after they left hospital.
- Staff recognised when patients needed additional support to help them understand and ask relevant questions about their care and treatment. Staff had telephone access to language interpreters if they were needed.
- Patients did not always know when their next appointment date would be when they left their outpatient clinic although they knew when to expect test results.

Emotional support

- The hospital supported patients to cope emotionally with their treatment. Patients were encouraged to link with other patients with the same condition and provide mutual support.
- We observed a group cardiac rehabilitation education session run by a physiotherapist. This informed patients about the symptoms of heart failure, the drugs used and who to contact at the hospital. It informed them about a community dietician who could help if patients wanted to lose weight. It provided patients with an opportunity to ask questions, find out how others coped and to get to know each other.
- In the cardiology service patients received counselling before major treatment and phone numbers of key people within the service. The post-surgery rehabilitation service offered support and guidance, and a routine phone call after six weeks.
- Specialities had clinical nurse specialists and advanced nurse practitioners. This provided more capacity in clinics and expertise. For example, there were five advanced nurse practitioners in breast care, and four nurse specialists in orthodontics.

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Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requiring improvement.

We found:

- Some people were not able to access services for assessment, diagnosis or treatment when they needed to. There were long waiting times, delays or cancellations.
- The orthodontics service at Glenfield Hospital was closed to new patients while patients in the backlog were treated. Of the 134 patients who were waiting more than 52 weeks for an appointment in May 2016, 130 were in the orthodontics speciality.
- The trust had problems with backlogs of patients needing following appointment, which it had not resolved. A patient waiting for an eye clinic appointment had been harmed because their appointment had not been prioritised.
- Service planning was not based on local need. There were shortfalls in how the needs of different people were taken into account, for example, planning to meet the needs of patients with learning disabilities.
- The cardiac rehabilitation clinic lacked space. The team had an office but no dedicated assessment areas and patients had to use toilets in the children's ward to put on and take off heart rate monitoring equipment.

However, we also found:

- Glenfield Hospital had patient-centred responsive services such as rapid access clinics and the GP open access imaging service. It planned for national campaigns such as Clear on Cancer.
- The services responded to individual needs and provided larger size chairs, a loop system for patients with a hearing loss and interpreters when this was necessary. The service learned from patient complaints and took action such as delivering customer service training.

Service planning and delivery to meet the needs of local people

- Service planning was not based on an analysis of local needs trust wide. The trust realised that demand for outpatient treatment and diagnostic processes was in excess of supply. The trust had not analysed capacity and demand for outpatient's services, or assessed the growth in demand for imaging services.
- The respiratory service took steps to ensure that services met the needs of the population. It planned its medical staffing for the Clear on Cancer campaign. They secured additional consultants and clinic times which would improve their 2 week wait performance
- Many of the facilities and premises were appropriate for the services being delivered. The breast care clinic planned its accommodation sensitively. There were two quiet rooms with pleasant soft furnishings where breast care nurses saw patients post diagnosis. A number of small waiting areas where patients waited for different procedures provided a calm, organised and uncrowded environment. The clinic rooms had a curtained off seating area where carers or relatives could sit while a patient was being examined. There was a hot and cold drinks machine and sandwiches were available from the catering service. The breast clinic provided patients with a car parking form to claim their money back if their clinic was running late.
- Restorative dentistry/orthodontics benefitted from an integrated laboratory on site. This meant the service could make changes to dental fittings immediately, which avoided the time involved in sending dental fittings away for adjustment. The laboratory used the most up to date materials and offered a bespoke service.
- The imaging service saw patients with tuberculosis (TB) separately from other patients. There was a higher than national average incidence of tuberculosis in Leicester. If a scan showed TB, the patient could have direct access to specialist nurses. However, there was no specific isolation unit for the imaging of TB patients. Staff acknowledged this was a risk but it was not recorded on the risk register.
- Cardiology offered a service which addressed local needs. The pre-admission service ensured that patients had staff contact numbers and included counselling before patients were admitted. The service received good patient feedback.

Access and flow

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- The orthodontics specialty at Glenfield Hospital was closed to outpatient referrals when we inspected. Of the 134 patients who were waiting more than 52 weeks for an appointment in May 2016, 130 were in the orthodontics speciality. The patients were overlooked due to incorrect waiting list management. The service transferred patients to alternative providers for more timely treatment.
- The trust carried out its own analysis of in-clinic waiting times and the causes of delay in October 2015. Patients and clinic co-ordinators completed a questionnaire per clinic identifying delays in patients being seen. The trust set a target of triage within 15 minutes. The data showed that 46% of patients were seen within 15 minutes of their appointment time.
- At Glenfield Hospital, 27% of patients waited more than half an hour, and the average wait time was 34 minutes. The reasons for the delays: 21.4% of clinics were overbooked; 10.8% of doctors were late to clinic; 19.6% patients arriving late to clinic; 19.6% patients becoming unwell during clinic; 7.2% medical staff teaching and 21.4% 'other' services.
- According to the analysis, the longest waits were in cardiovascular, renal, respiratory, ophthalmology, orthopaedics, plastics, breast care, maxillofacial, oral surgery and ENT. The cardiovascular, respiratory, and breast care specialities held clinics at Glenfield Hospital.
- Overbooking of outpatient clinics (booking more than one patient to the same appointment slot) created problems and sometimes there were up to four patients waiting for one appointment time. Staff explained appointments were overbooked because patients sometimes did not attend their appointments and there were not enough clinic slots available. However, between the percentage of appointments which patients did not attend trust wide between April 2015 and March 2016 was 5% (Hospital Episode Statistics) This is below the England monthly average.
- Overbooking of this sort did not conform with the trust's own policy. The trust's Outpatient's Clinic Template Management UHL Policy stated that 'All patients will be scheduled to attend at a realistic time to avoid several patients attending simultaneously for an individual appointment time and then having to wait.' Clinical need was the only basis for adding patients to a clinic which was already full.
- We spoke to two patients waiting for the positron emission tomography (PET)/ computerised tomography (CT) scan delivered by an external provider working under contract for the trust. They were grateful for the quick appointment and did not mind the short notice they were given. They were happy to travel from outside of Leicester, found the administration was good and already had a follow-up appointment organised.
- The clinic which patients attended to have blood specimens taken (phlebotomy) was waiting for a white board to display the estimated waiting time for patients; when we inspected this was not available Staff told us this was an average of 30 minutes at busy times but could be up to an hour.
- The trust cancelled outpatients appointments more than the England average. From April 2015 to March 2016 (Hospital Episode Statistics) the England average was 7% whereas the trust cancelled 16% of patient's appointments. Glenfield Hospital cancelled 18% of clinics over this period. Some individual clinics cancelled more than this. For example, the trust's statistics showed from June 2015 to May 2016, 19% of breast surgery outpatients, 27.5% of cardiology, 38% of rheumatology and 18% of restorative dentistry patients had their appointments cancelled by Glenfield Hospital.
- The trust did not show us an analysis showing why clinics were cancelled or action plans to address this. We spoke with patients who had their appointments cancelled three or four times. This created patient dissatisfaction, a need to clinically re-assess patients in some cases, and complications with rebooking.
- The trust had difficulty managing waiting lists which included follow-up appointments. The ratio of new appointments to follow-ups was similar to the England average in 2015.
- The trust had problems with backlogs of patients needing following appointment, which it had not resolved. A patient waiting for an eye clinic appointment had been harmed because their appointment had not been prioritised. Although this did not happen at Glenfield Hospital, the problem of managing waiting lists was trust-wide.
- Four patients across three different specialties waited more than 52 weeks to be treated in May 2016. The trust had responded and ensured that the patients were treated. The trust was working on management

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arrangements to keep performance for outpatients on track. However, when we inspected, it had not assessed capacity and demand across the range of outpatients specialities.

- Diagnostic imaging had long waiting lists of patients waiting for their scan. In May 2016, there were 1012 magnetic resonance imaging, 655 computerised tomography and 139 ultrasound patient scans waiting to be authorised and nine of each category were urgent two week wait referrals.
- Trust wide, diagnostic imaging did not meet its own target of 80% of cancer imaging within 7 days. It achieved 62.3% in May 2016. MRI scans also missed 1% of scans to be more than 6 weeks, with 2% exceeding 6 weeks. The trust did not record imaging performance by site.
- Diagnostic imaging had a reporting backlog of 10274 chest and abdomen plain film x-ray images, caused by a focus on cross sectional imaging to the detriment of plain film x-rays. The service had a plan to report on all of the images in the backlog. This included checking the data, prioritising patients on the basis of clinical need and recruiting 11 radiographers experienced in reporting, to ensure that they reduced the backlog to two months of plain film imaging by end of June 2016.
- Administrative processes were sometimes unreliable. Patients told us that on occasion they were invited to the wrong clinic, given the wrong time or sent a follow up letter when they had not had their first treatment. The trust recognised this as a risk and was recruiting to vacant administrative posts and training their staff.
- The trust met its waiting list target of 92% of patients being treated within 18 weeks in May 2016, but reported that it was likely that it would not achieve the target in June 2016 because of Ear Nose and Throat (ENT), allergy and orthopaedic clinic waiting times. This target covers both the outpatient and inpatient journey. The earlier patients were seen in outpatient clinics, the quicker they would be seen for inpatient treatment such as an operation, if this was needed
- Glenfield Hospital had arrangements to see some patients in a timely way. The imaging service had an x-ray facility in the clinical decisions unit (CDU) which had a rapid turnaround. It produced x-rays within 30 minutes for CDU patients and in an hour for inpatients. It was open from 9 am to 5 pm but available on-call at other times. The diagnostic imaging service had a GP open access service with a 48 hour turnaround time.

- The pacemaker clinic could react quickly to patient needs. Urgent appointments could be made from the wards. The clinic saw 50 patients a day. Patient waiting times were approximately 10 minutes, unless the clinic technicians needed support for unwell patients that had been referred urgently from a cardiac clinic.
- Some specialties offered rapid access clinics. A rapid access respiratory clinic at Glenfield Hospital was very popular which led to it being crowded. The service responded by extending the clinic over two days which helped to address the problem.
- The respiratory clinic (not rapid access) started to address the problem of in-clinic waiting times, where sometimes four patients were booked into one time-slot. They stopped this overbooking and planned a mix of new appointments and follow-ups so both patient groups could access services. This was planned to go live in September 2016.
- Telemedicine, which is the use of technology to provide clinical services when the consultant and patients were not in the same place, was used in breast care and cardiology. They gave telephone consultations which saved patients a journey to the clinic.

Meeting people's individual needs

- The trust had difficulty meeting the needs of patients with a learning disability. The 3rd May 2016 Clinical Support and Imaging safeguarding committee discussed high rates of Did Not Attend figures for patients with learning disabilities, but was not specific about the number. This was because care home staff were unable to attend with the patients or because of patient illness. Outpatients staff did not know if people had a learning disability until they arrived in outpatient clinics unless it was stated in the GP's letter. This meant that clinics could not always prioritise these patients and see them in a timely manner.
- Dementia champions ensured staff were aware of what needs patients with a dementia may have. A dementia champion is a member of staff who encourages others to make a positive difference to patients living with dementia. They do this by giving them information about the personal impact of dementia. Patients with dementia would be taken to a quiet area and prioritised for an appointment. This minimised the disorientation and distress to them.
- The cardiology service responded to individual needs. There were different sizes of chairs in the waiting area

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including a chair for a person who was a larger size (bariatric). The reception desk had a hearing loop for people who had difficulty hearing. A lifestyle coach assisted cardiac patients with rehabilitation.

- Clinics were able to access interpreting services either over the phone, or could book a face to face interpreter. Not all clinics had a sign language interpreter, so they would find one from another clinic if they needed to.
- Diagnostic imaging had an arrangement with an external provider to deliver the positron emission tomography (PET) scan facility at Glenfield Hospital as well as the computerised tomography (CT) scan facility. A PET scan is an imaging test that allows doctors to check for diseases in body. The scan uses a special dye that has radioactive tracers. We spoke to two of the provider's staff. They knew which numbers to call in an emergency and had a folder with essential reference information for each site.
- We spoke with six patients in cardiology who all told us they were happy with the service. Their appointments were either on time or less than half an hour late. One patient told us there was no direct consultant to consultant referral system from gynaecology to cardiology, but otherwise they thought that everything was fine.
- The cardiology service displayed informative leaflets prominently in the waiting area. These explained common diagnostic procedures such as echocardiography, exercise tests and taking ambulatory blood pressure.
- There were leaflets which explained surgical procedures such as heart valve surgery. Breast care leaflets were provided in English, Gujarati and Polish. Staff could arrange for other languages to be provided if the patient requested this.
- Not all facilities were dignified. The changing areas in diagnostic imaging were shared between male and female patients. This suited a few patients who arrived in a family group, but for many people it was not dignified. The service was trialling different arrangements, such as holding separate sessions for male and female patients to solve this problem.
- The cardiac rehabilitation clinic lacked space. The team had an office but no dedicated assessment areas and patients had to use toilets in the children's ward to put on and take off heart rate monitoring equipment. Restorative dentistry/orthodontics waiting area was stocked with informative leaflets about dental care.

Learning from complaints and concerns

- The number of complaints at Glenfield Hospital relating to diagnostic imaging amounted to nine and were mostly related to staff attitude. The service responded to complaints about staff attitude in ultrasound by delivering customer service training. When we inspected, the service had not evaluated how effective the training was.
- Over half of the total of complaints made to the trust were about outpatients clinics. We reviewed complaints from March 2015 to March 2016, and found 58% of complaints concerned outpatients clinics and 5% (43 in total) were about diagnostic imaging services.
- Within the total of complaints about trust outpatient clinics, 30% (138) concerned outpatient clinics at Glenfield Hospital. Complaints were mostly about communication and administrative arrangements such as appointments. Staff at Glenfield Hospital told us they tried to resolve complaints as soon as possible if patients complained to them face to face.
- The main causes of complaint for outpatients at Glenfield Hospital were the pay and display parking rather than pay on exit and the in-clinic waiting times for some consultants.
- Diagnostic imaging services received some complaints from general practitioners (GPs) about rejected referrals but the number of complaints about waiting for scan reporting reduced compared to the previous year.
- Patients sometimes waited a long time for transport from an external company to arrive to take them home after outpatients or imaging appointments. Two patients, one of whom had complained in writing, told us that although they received treatment in the morning, they did not get home until late in the evening because of patient transport. Outpatient staff sometimes waited with patients until 8:45pm, and imaging staff checked on patients until late. Staff highlighted that patients from care homes who arrived in ambulances sometimes waited in excess of four hours or a whole day for transport to arrive to take them back to the care home after scans or treatment. Staff were concerned about patients living with dementia or pressure ulcers. They recorded the delay on the electronic incident reporting system. The transport contractor performance had not improved however.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We rated 'Well led' as requiring improvement.

We found:

- Departmental risks, issues and poor performance were not always dealt with appropriately or in a timely way. Risks were not assessed or recorded at site level and not all risks were on the risk register, for example the backlog in appointments, high clinic cancellation rates and capacity was not meeting demand.
- The risk register identified the lack of outpatient appointment follow up appointments and used a system to prioritise in date order but did not monitor the ongoing clinical risks that may affect patient safety.
- Governance arrangements for better waiting list management were in development and were yet to improve the patient experience when we inspected.
- Although outpatient services monitored quality, this was not reflected in quality and safety dashboards and outpatients did not compare their services to others. Planning to provide future capacity to meet demand was not fully in place.

However, we also found:

- Staff understood the trust's values and priorities. They found the chief executive approachable and felt supported by their local leaders. There was a positive working culture at Glenfield, and innovative practices. Services listened to patient feedback and made changes as a result.
- Diagnostic imaging staff understood the short term vision for delivery of their service.

Vision and strategy for this service

- There was a clear vision and quality and safety were the top priority. The trust had a five year plan - 'Delivering Care at its Best.' The trust aimed to provide safe, high quality patients centred care and deliver services which consistently met national access standards.
- Diagnostic imaging staff understood the short term vision for delivery of their service. Part of this was joining the East Midlands Radiology Service (EMRAD) in August

2016. This was a project to set up new shared imaging arrangements between East Midlands hospitals with shared staff, services and resources. This aimed to provide services 24 hours a day, seven days a week.

- The trust planned to relocate outpatient booking and clinics at Glenfield Hospital and have satellite clinics in Leicestershire and Rutland towns in a 'hub and spoke' model. Clinicians understood and supported the idea of moving general clinic consultations out to the community, to the smaller Leicestershire local hospitals. This would mean services could meet local demand. They recognised that this needed some assessment of capacity and demand, so that they could ensure there were enough consultants to run the clinics.
- The Clinical Support and Imaging clinical management group annual plan stated how it would contribute to trust annual priorities. Among its annual plan priorities it listed: acquiring new machines in 2016/2017 combined with 7 day working on existing machines, achieving Imaging Services Accreditation Scheme status and further centralisation of outpatient bookings to a central booking centre and having clear information about which clinic rooms were in use. The clinical management group board meeting reviewed progress on annual plans under a standing item 'strategy update' on the agenda.
- Other clinical management group action plans were less explicit about how they would contribute to better quality and waiting times for outpatients. For example, the cancer, haematology, urology, gastroenterology and surgery (CHUGGs) clinical management group planned to take outpatient services out to community settings, and renal, respiratory and cardiovascular(RRCV) clinical management group intended addressing complaints in cardiology. Actions which matched future capacity to demand in outpatients were not explicit. This did not assure us that future capacity would meet demand in outpatient clinics.
- Most outpatient staff knew about the trust's values and the priorities. They understood the values such as: we treat people how we would like to be treated' and 'We do what we say we are going to do.' Some were aware there was a vision to centralise outpatient services at Glenfield; however, they did not feel involved in the plans and were unclear about their role and timescales.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- The governance arrangements for outpatients clinics were complex. The clinical and support and imaging (CSI) clinical management group included diagnostic imaging, the booking centre and medical records departments for all three sites. Other clinical management groups managed some bookings, the number of appointments per clinic and doctors and specialist nurses.
- There were quality and safety meetings at clinical management group at senior level and nursing staff also discussed quality in their own teams. Nursing staff at all levels attended a monthly meeting where they discussed incidents and patient feedback. Discussions resulted in action plans to incorporate learning into day to day working.
- The trust lacked management information to be able to performance manage outpatient services robustly. They did not have reliable information about the availability of clinic space but were planning to implement clinic booking software to manage this better. Staff collected clinic booking information at a local level to enable better planning of services. External consultants were assessing capacity and demand in specialities.
- Staff had begun to monitor in-clinic wait times. This was reported back to clinical management group board level. This enabled clinics to see when rooms were cancelled and how they were used. A programme management board oversaw all of these initiatives. However, this initiatives were in the early stages, and we did not see any beneficial impact for patients in the clinics we inspected.
- The trust's departmental risk management was not effective. It did not identify risks to follow up patients in specialities such as the eye clinic or rheumatology so that managers could take preventive action. However, the trust had a risk register and reviewed risks regularly at CMG boards.
- There was no site-specific risk register for Glenfield Hospital; instead the outpatient risk register was trust-wide. It did not identify all risks, for example, it did not include the leaking roof at Glenfield. The risk of sending out delayed outpatient letters was reflected in the corporate risk register, but other risks such as outpatient backlogs, were not.
- The risk register identified the lack of outpatient appointment follow up appointments and used a system to prioritise in date order, but did not monitor the ongoing clinical risks that may affect patient safety. At the time of our inspection this risk register entry had not been reviewed for five months.
- The trust had a weekly access meeting to monitor performance on the 18-week waiting list target. It aimed to find solutions for patients who had waited a long time, and deal with any limitations on performance, for example staffing shortages. However, this was management driven and did not have any nursing representatives from the outpatients clinics.
- Departmental risks, issues and poor performance were not always dealt with appropriately or in a timely way. Managers did not set targets at clinic level for wait times, appointment slots available or % of patients surveyed for Friends and Family Test feedback. We did not see cleaning audits displayed consistently or 'you said, we did' information.
- A framework was in place to coordinate improvement actions towards Department of Health performance targets for outpatient's treatment and diagnostic imaging. An outpatient programme board with representatives from the clinical management groups focused on cost and efficiency improvement initiatives. This group programme managed improvements such as centralising outpatients bookings, improving the uptake of the Friends and Family Test by patients and shortening in-clinic wait times.
- The trust provided remedial action plans for commissioners which detailed how it would improve waiting list times. Commissioners monitored waiting list performance on a monthly basis. We saw action plans for orthopaedic surgery, including outpatients which included weekly reviews of all patients without an appointment date, and staff training on the 18 week waiting list target. For the allergy service their action plan included diverting resources from the ward to outpatients, setting up dietician and nurse clinics, and refining the pathway of referrals from the emergency department. When we inspected, it was too early to assess the impact. The trust also had an ENT and cancer recovery plan. They had started outsourcing extra clinics to locums in May and June 2016. They outsourced to locums some urgent scans for cancer patients at the same time as recruiting more head and neck consultants to ensure there was sufficient capacity in the service in the future.

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- Each specialty had quality and safety meetings at clinical management group senior level and nursing staff also discussed quality in their own teams. Nursing staff at all levels attended a monthly meeting where they discussed incidents and patient feedback. We saw their action plans on learning from incidents to show they changed practices as a result.
- Managers put in place a scorecard and had meetings to monitor outpatient clinic performance. Each speciality had a performance scorecard which included booking slot utilisation, new to follow up ratios, cancellations by patient and hospital and did not attend (DNAs) and reported key information to the weekly access meeting. A programme management board oversaw this and improvement initiatives, such as centralising outpatients bookings, improving the uptake of FFT and shortening in-clinic wait times. However, these initiatives were in the early stages, and we did not see any beneficial effect for patients in the clinics we inspected.
- The trust had specific governance arrangements for cancer services. The cancer action board met monthly and included representatives from theatres, imaging, oncology, radiotherapy and chemotherapy. This analysed patient progress on an individual basis and investigated if a cancer patient had to wait more than the target time. The Director of Performance telephoned underperforming services daily, such as lung cancer and urology, to ensure appropriate action was taken for patients.
- The diagnostic imaging service quality assured their services where this was expected, for example, CT scanning of the breast or colon. They had a programme of audits for x-ray, computerised tomography and magnetic resonance imaging were developing audits for ultrasound. The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) policies were monitored by the Imaging Radiation Protection Group. They reviewed quality and safety issues at the CSI clinical management group board meeting.
- Joint working arrangements with partner organisations did not ensure good performance for patients. Patients sometimes waited a long time for transport from an external company to arrive to take them home after outpatients or imaging appointments. Staff highlighted these concerns and recorded the delay on the electronic incident reporting system. The transport contractor performance had not improved.

Leadership of service

- Overall leadership for outpatients was unclear. The head of operations for clinical support and imaging led the administrative, booking and process improvement aspects of outpatient clinics. Other clinical management groups oversaw outpatient clinics within their specialties from a clinical point of view. For example, clinical leadership of the rheumatology outpatient clinic was provided by the head of the rheumatology service in the acute medicine clinical management group. .
- Staff told us they could have ‘breakfast with the boss’. They could make an appointment with the chief executive to discuss any issues they might have. They knew members of staff who took the opportunity to do this. The chief executive got back to staff with answers if he could not respond to them at the time. The chief executive had a monthly briefing. He followed this up with an email update to each member of staff. Nurses said they met with clinical management group heads of nursing but did not know the trust chief nurse.
- Staff felt valued and well supported by local leaders such as their line managers and head of nursing and general manager.
- Diagnostic imaging staff said the their new management structure was effective and they were complimentary about d the general manager’s leadership.

Culture within the service

- Outpatients and imaging staff told us they felt respected and valued at Glenfield Hospital. There was a supportive culture and staff told us they felt confident to raise any concerns
- Glenfield Hospital outpatients and diagnostic imaging services had a relatively high sickness rate at 6.2%, for April 2015 to March 2016. Sickness was 6.2% at LGH and 3.2% at LRI. This was above the average for the trust which was 3.8%.
- Staff turnover, although high, compared well with the other Leicester hospitals at 9.6% with a vacancy rate of 6.9%. High turnover and sickness can be a sign of a difficult culture to work in.
- Staff felt that the culture had improved across the trust since the chief executive had been in post.
- The cardiac rehabilitation service networked across the hospital’s sites. This enabled the services to discuss performance challenges and to share knowledge about

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audit and research projects, for example, how to implement an exercise class for stroke patients twice a week exercise class for six weeks as part of a research project.

- The diagnostic imaging service told us there were different cultures across each of the trust's sites. Staff thought well of Glenfield Hospital because of its lower turnover rates and supportive culture.

Public engagement

- Leaders prioritised the participation and involvement of people who used services. The trust had a group of patient partners to advise on development from the patient's perspective. A patient partner assisted the imaging manager on proposals for interventional radiology and privacy and dignity improvements at Glenfield. Another member of the group was a member of the Outpatient Programme Board and advised on improving the patient experience within outpatient services.
- Diagnostic imaging made changes as a result of patient feedback. The service introduced solid cubicles in patient changing facilities when patients complained about curtains.
- In the breast care clinic there was a 'how are we doing?' board in the patient's waiting area which displayed comments from patients. These included positive comments, such as 'very quickly seen', 'clean waiting area', and 'very polite staff.'
- The thoracic medicine clinic acted on patient's feedback it obtained from 'Message to Matron' cards. It provided copies of free newspapers in the waiting area in response to patient's comments.
- The trust's outpatient feedback was collected electronically, either on a device in the clinic, a touch screen device situated in the reception areas in all three hospitals or via the trust's website. The Friends and Family Test question was followed by a free text box that allowed patients to give the reason for the answer they have given. The free text box could be accessed at any time while the patient was completing the survey, for example when completing the questions about their care and treatment.
- The trust produced a range of publications for the population it served. These were published for the members of the public to access and included an

annual quality account and an updated 5-Year plan, which brought the public up to date with the trust's progress against its objectives and priorities, one year into the plan.

- In addition, we saw that the trust held a public engagement forum every three months. The forum was open to all members of the public and provided an opportunity to talk about any issues that were concerning patients and carers. For example talking about what actions were being carried out to try and avoid cancelling operations

Staff engagement

- The breast care service had monthly staff meetings which were minuted. Staff could influence the agenda by adding to a list of issues for discussion which was placed in the staff room.
- The trust adopted an NHS staff engagement initiative called 'Listening into action.' Each outpatient speciality set up 'Link Teams'. They created resource folders with reference information, for example how to prepare the clinic, information on patients' needs, and doctor's preferences. This led to rotas for the cleaning of specialist trolleys and equipment for outpatients clinics. This increased staff knowledge and confidence to work in a new clinic, because they could readily access the reference information.

Innovation, improvement and sustainability

- Respiratory services rehabilitation compared resources and strategies with those at other trusts, and improved their in-service training as a result.
- Cardiac rehabilitation held cross site meetings with other trust locations which enabled them to share information about improvements and compare good practice.
- The diagnostic imaging service innovated and developed the service. They compared their staff training and recruiting arrangements with other trusts. They had a GP direct access service and were offering fixed appointments on Saturdays for GP referrals. They planned to improve access and flow in the hospital by locating x-ray room for inpatients in the clinical decisions unit to minimise travel and keep patients safe. This aimed to see 70% of clinical decisions unit patients admitted to the unit within 30 minutes and 100% of patients within four hours. Glenfield hospital cardiologists developed an online rehabilitation

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programme with patients called 'Activate Your Heart' This provided patients with coronary heart disease with an online cardiac rehabilitation programme to manage their condition themselves, as an alternative approach to formal cardiac rehabilitation The licence has been sold to NHS Scotland.

- The "SPACE for COPD" online pulmonary rehabilitation programme was designed by pulmonary rehabilitation specialists at UHL with the aim of helping individuals with chronic obstructive pulmonary disease to manage their condition more effectively. Training manuals have been sold to other trusts and pharmaceutical companies.

Outstanding practice and areas for improvement

Outstanding practice

Medical care

- An initiative to improve the timely administration of medicines for Parkinson's disease (PD) had been put in place across the trust and we saw evidence of this in use at the Glenfield hospital. Ward staff told us they were aware of the PD medication stock held on the clinical decision unit (CDU) and this reduced requests for these medicines out of hours and ensured patients received their medicines when needed.
- Patients on the coronary care unit could be monitored remotely using mobile cardiac telemetry (MCT). This meant patients could mobilise whilst undergoing continuous cardiac monitoring.
- A 'pain aid tool' was available for patients who could not talk and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, body language and physical changes to help determine level of patient comfort.
- A comprehensive two-year competency based training programme was in place on the coronary care unit (CCU). Competencies included; intra-aortic balloon pump (an intra-aortic balloon pump is a mechanical device that helps the heart pump blood), continuous positive airway pressure, a treatment that uses mild air pressure to keep the airways open, high flow oxygen and advanced life support.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital.

- The respiratory early discharge scheme (REDs) was in place to speed up hospital discharge for respiratory patients, especially those with chronic obstructive pulmonary disease (COPD).
- Bereavement services were offered to families and they were invited back to the hospital for a 'day to remember' event. Where there was an opportunity to talk to other families and relatives. They released memorial balloons and also had an opportunity to revisit the critical care unit should they wish to.

Surgery

- A 'Pain aid tool' was available for patients who could not verbalise and/or may have a cognitive disorder. This pain tool took into account breathing, vocalisation, facial expressions, and body language and physical changes to help determine level of patient comfort.
- The trust recognised that families, friends and neighbours had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. This also included children and young people with caring responsibilities. As a result, the 'UHL Carers Charter' was developed in 2015.
- The development of 'my lung surgery diary' by the thoracic team, with the help of patients during the patient experience day 2015.

Services for children and young people

- The pain management service won the national Grünenthal award for pain relief in children in 2016. The Grünenthal awards recognised excellence in the field of pain management and those who were striving to improve patient care through programmes, which could include the commissioning of a successful pain management programme.

Areas for improvement

Action the hospital MUST take to improve Medicine

Outstanding practice and areas for improvement

- The trust must take action to ensure nursing staff adhere to trust guidelines for the completion and escalation of early warning scores (EWS).
- The trust must take action to ensure nursing staff adhere to the trust's guidelines for screening for sepsis in the ward areas and in the emergency department.

Surgery

- The provider must ensure that appropriate systems and training are in place to ensure that Consent forms are completed appropriately for patients who lacked capacity and were made in line with the Mental Capacity Act 2005.

Critical Care

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.

Services for children and young people

- The hospital must improve the numbers of staff on each shift trained in Advanced Paediatric Life Support and European Paediatric Life Support Royal College of Nursing (RCN) 2013 staffing guidance. Training levels for Paediatric Life Support were low so there was insufficient staff who were suitably trained.

End of Life

- The trust must ensure 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms are completed appropriately in accordance with national guidance, best practice and in line with trust policy.
- There were insufficient numbers of suitable syringe drivers with accepted safety features available to ensure patients would receive safe care and treatment.

Action the hospital SHOULD take to improve

- The trust should ensure fire prevention and safety is given sufficient priority at all times.
- The trust should ensure medical staffing on ward 28 is reviewed to maintain appropriate levels of support for junior medical staff.

- The trust should ensure a sufficient number of staff trained as 'scrub assistants' are available on the angio-catheter suite.
- The trust should ensure the referral to treatment times (RTT) for the cancer standard and access to diagnostic tests within six weeks of referral are reviewed with actions in place to improve services.
- The trust should ensure fluid balance charts used to record a patient's fluid intake and output are adequately completed in order to monitor a patient's fluid balance to prevent dehydration or over hydration.
- The trust should consider publicly displaying safety thermometer data in order that patients and the public could see how the ward was performing in relation to patient safety.
- The trust should consider seven-day working for medical staff across the medical specialties
- The trust should ensure that the actions initiated after the recent never event include re-enforcing the importance of the timely reporting of all incidents.
- The trust should consider how it is going to meet the existing areas of non-compliance with the D16 National Service Specification for Adult Intensive care. More specifically, the shortfall in allied health professional support and NICE guidance.
- The trust should consider how it is going to reduce the number of cancelled elective surgery cases.
- The trust should locate, monitor and track the syringe drivers across the trust.
- The trust should review the leadership arrangements and focus on end of life care to ensure it is given sufficient priority at directorate and board level.
- The trust should ensure that cleaning arrangements are adequate, formalised and monitored.
- The trust should minimise in-clinic wait time for patients and check their pain levels
- The trust should train outpatient booking staff in good booking and patient management practices.
- The trust should plan services to meet local need. The trust should ensure that it has access to all necessary information about the service in order to mitigate risks to the quality and safety of treatment.
- The trust should implement transparent quality, safety and performance arrangements, for example, consistent use of quality dashboards.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (2) Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service. How the regulation was not being met: The provider did not have an audit system in place to ensure 'Do Not Attempt Cardio-Respiratory Resuscitation' decisions were always documented legibly and completed fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005.
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 (2)(a) Service users must be treated with dignity and respect, ensuring the privacy of the service users. How the regulation was not being met: Not all patient tests were carried out in private surroundings, this compromised patients privacy.
Regulated activity	Regulation

Requirement notices

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (2)(a)

Care and treatment must be provided in a safe way for service users by assessing the risk to the health and safety of service users of receiving care and treatment.

How the regulation was not being met:

- There was an ineffective system in place to assess, monitor, and mitigate risks to deteriorating patients, Nursing staff did not consistently adhere to trust guidelines for the completion and escalation of Early Warning Scores (EWS); frequencies of observations were not always appropriately recorded on the observations charts and medical staff did not always documented a clear plan of treatment if a patient's condition had deteriorated.
- Where patients had met the trust's criteria for sepsis screening, not all patients were screened in accordance with national guidance.

Regulation 12 (2)(e)

Care and treatment must be provided in a safe way for service users ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way

How the regulation was not being met:

- There were insufficient numbers of suitable syringe drivers with accepted safety features available to ensure patients would receive safe care and treatment.

Regulation 12 (2)(g)

The proper and safe management of medicines

Care and treatment must be provided in a safe way for service users

How the regulation was not being met

- At Glenfield Hospital, one locked cupboard in Clinic B, the asthma clinic, contained FP10 prescriptions but there was no audit trail for their use.

Requirement notices

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1)

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.

How the regulations were not being met:

- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- Training shortfalls existed in Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training. This meant the service could not provide at least one nurse per shift in each clinical area trained in APLS or EPLS as identified by the Royal College of Nursing (RCN) 2013 staffing guidance. Training levels for Paediatric Life Support were low so there was insufficient staff who were suitably trained.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11(1) HSCA (RA) Regulations 2014 Need for consent

Regulation 11(1)

When a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

- The provider must ensure that appropriate systems and training are in place to ensure that Consent forms are completed appropriately for patients who lacked capacity and were made in line with the Mental Capacity Act 2005.