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	Good
Accident and emergency	Requires improvement
Medical care	Good
Surgery	Good
Intensive/critical care	Good
Services for children & young people	Good
End of life care	Good
Outpatients	Good

Summary of findings

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Summary of findings

Overall summary

Glenfield Hospital is part of the University Hospitals of Leicester NHS Trust, a teaching trust that was formed in April 2000 through the merger of Glenfield with Leicester General Hospital and Leicester Royal Infirmary. It also incorporates St Mary's Birth Centre. The trust provides care to the people of Leicester, Leicestershire and Rutland as well as the surrounding counties.

Glenfield Hospital has 417 beds and provides a range of services (elective and non-elective), which include medical care services for lung cancer, respiratory and breast care. It is also the base for the trust's heart centre, providing treatment for conditions including heart disease. We spoke to 43 patients and their relatives while visiting the wards and departments in the hospital. We also held a listening event on Monday 13 January where we spoke with around 80 people who came to provide their views on this and the other hospitals managed by this trust.

This hospital does not have an accident and emergency (A&E) department but has a clinical decisions unit which we cover in the A&E section of this report. The hospital also has a Paediatric Intensive Care Unit, which we cover in the 'services for children and young people' section of this report.

Prior to and during our inspection we heard from patients, relatives, senior managers, and all staff about some key issues which impacted on the service provided at this hospital. Across the trust there were three issues which the trust management team had alerted us to which impacted at all locations these included staff shortages, pressures on all areas from the A&E department and the impact of the contracted out services. These three issues are discussed in detail in the trust overview report. The issues of most concern in this location include:

Inappropriate patient transfers

While the main capacity issues for the trust lay at the largest site, Leicester Royal Infirmary, these impact at the Glenfield Hospital site as patients are diverted to the clinical decisions unit when some patients are diverted from A&E, impacting on the effectiveness of this service. This also means that inappropriate patients are sent to the unit and later transferred across the trust to the appropriate ward. Patients waiting for beds within main wards are cared for by a different medical team each day and this could lead to inconsistencies in treatment. Within the surgical unit we found that patients were regularly being transferred between wards to facilitate bed management issues.

Infection prevention and control

We saw a number of issues where infection control procedures required review. These included the cleaning of patient equipment, poor hand washing procedures and dirty equipment. These could have an impact on control of infection and increase cross contamination.

Outpatients services

The outpatients services are partly driven by the central booking service located on this site. While we heard from a number of sources that long waiting times in outpatients was a result of overbooking, we found that the central booking service had strict criteria to operate under. Where appointments for patients could not be found within these criteria, the referral would be sent back to the department to be dealt with.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The Glenfield Hospital generally provided safe care for the patients it treats, but some improvements were required to ensure that patient safety was maintained at all times. The trust acknowledges the shortages in staffing and is actively seeking to recruit to the vacancies; however, gaps in staffing do have an impact on patients despite the immediate actions taken by the trust. We saw that in the intensive care unit the names of new recruits were displayed and had already been allocated a mentor. This ensured that all staff were aware of the actions taken by the trust to fill vacancies.

Infection prevention and control practices were not consistent across the hospital with some areas found to have dirty equipment and inappropriate cleaning procedures. Water provided to patients was seen to be drawn from hand washing sinks rather than sinks in the kitchen area. This water not ideal for drinking.

In surgery the assessment of risks did not always occur, and when this did, actions were not always taken to address risks identified. Staff were unclear about whose responsibility the assessment of risk of thrombosis was.

Are services effective?

Good

Glenfield Hospital provides specialised services, in particular cardiac and respiratory services. The information we reviewed before visiting this hospital indicated that it was functioning effectively and that patients' outcomes were good.

Glenfield Hospital undertakes respiratory and cardiovascular services which are nationally respected. The national audit data reflects the good practice and outcomes for patients that this specialised service achieves.

We found that the trust responded well to clinical audits of its services and we saw some positive actions as a result of these. This included the use of 'falling leaves' picture indicators to identify patients who were at high risk of falling, the instigation of dementia champions and older person's champions.

Are services caring?

Good

We found that all staff were caring. Patients commented that they felt positive about their admission to this hospital. The NHS Friends and Family Test shows that patients would recommend all of the wards to their family, which implies that they received caring treatment. We saw a number of staff going the extra mile to ensure that patients' needs were met and we saw some outstanding care in specialised areas.

Summary of findings

We saw and heard that the trust had implemented the Listening into Action approach to engage the right people in quality outcomes, which enabled staff and patients to feed ideas and suggestions into the management team. We saw a number of areas where action had been taken to improve care as a result of patients' feedback.

Are services responsive to people's needs?

Good

The trust has a number of systems and processes in place to ensure it receives feedback from patients and their families. We were told of and saw a number of changes to practices and care as a direct result of patients' feedback. This included patient information screens in the intensive care unit to provide local information about Leicestershire for relatives who were visiting from outside the area.

We found that the pressure on beds was reduced at this site due to the location of A&E services at Leicester Royal Infirmary. However, increased demand for the services did, at times, result in the clinical decisions unit becoming extremely busy and sometimes taking inappropriate admissions.

Access to the hospital was good and the environment met the needs of patients and visitors. The hospital had some outdoor areas which patients and their relatives could access with ease.

Are services well-led?

Good

The trust has recruited to a number of senior posts during the previous year. These include a new chief executive at the beginning of 2013 and a new chief nurse in September 2013. We spoke to staff who told us that they were very clear on the direction for the trust. Staff felt that the new chief executive and chief nurse were very visible in the hospital and supportive of issues raised with them.

Staff told us that there was a new culture within the trust and that they were not afraid to raise concerns at this hospital. Staff felt that local managers were supportive and we saw some excellent team working. Staff received information from senior management and had appraisals to review their performance.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Requires improvement

The Glenfield Hospital does not have a walk-in A&E department. Instead, it has a clinical decisions unit which provides urgent treatment and assessment for patients with respiratory and cardiac health problems. In general, these patients are brought into hospital by ambulance, or referred by their GPs.

Services in the CDU were generally safe and effective, because there were systems in place to identify, investigate and learn from incidents. However, we found that sometimes care was delayed due to the pressure on the service. This meant long waits for treatment at times. Pressures on the department were increased when a divert was in place from the main A&E service and this led to inappropriate admissions to this unit.

Patients were assessed and received treatment that was appropriate to their needs. Patients and their families were involved in their care and given time to think through treatment options.

We saw that care was planned on evidence-based guidelines and staff were receptive to the needs of their patients. However the unit was currently recruiting to the 10 vacant nursing posts. This impacted on the care provided to patients as nursing staff were very busy and could not always attend to people's needs.

The department was well-led with staff feeling supported and able to make decisions.

Medical care (including older people's care)

Good

Services for medical care were generally safe and effective, because there were systems in place to identify, investigate and learn from incidents. However, we found that sometimes care was not delivered in line with the trust's infection prevention and control policy, which placed people at risk.

Ward staff assessed patients' risks for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients were deteriorating. We found that, although staff were busy, they were available to meet people's needs. However some equipment was found to be dirty, dusty and not regularly checked.

The trust had a dementia strategy in place and there was an active network identified as champions for older patients and those with dementia. This improved care for patients with dementia and enabled early identification of these patients. Initiatives to ensure that discharge was appropriate and timely were having an impact at this hospital.

The wards/departments were generally well-led. Local management set an open culture in which staff felt supported and able to raise issues. The initiatives that had been introduced trust wide were embedded at Glenfield Hospital, these included Listening into action and caring at its best.

Summary of findings

Surgery

Good

Surgical services at Glenfield Hospital were safe because staff know how to report incidents and action was taken as a result of these. However staff reporting these incidents did not always receive feedback about the incident that they had reported. National guidelines are followed by staff to ensure that patients are safe when undergoing their operations. However risk assessments for thrombosis and pressure sores were not always undertaken which led to increasing incidents at this location.

We found that staffing levels were, overall, much more stable at this location but did not always meet the trust's agreed levels. We found that national guidance was not always followed and this posed a risk to patients. Patients experienced a number of transfers between wards at this site which led to a poor patient experience.

We found that the provision of care was well-led and that leadership was robust. Staff felt that communication had improved, management was more cohesive and accessible and the culture of the hospital was good with positive changes to senior management structures and governance.

Intensive/critical care

Good

Patients received safe, effective and responsive critical care services. There were enough specialist staff to meet people's needs and ensure that they had appropriate, 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate.

There was always sufficient equipment available to meet to the needs of the patients. Patients' medications were stored securely and were within their expiry dates. The ICU was visibly clean and well-maintained. There was an adequate amount of space, particularly between each patient's beds. Patients had either one-to-one nursing, or one nurse to two patients. Patients were supported to make decisions about their care, where possible, and relatives were involved in their family member's care.

Services for children & young people

Good

Services in the paediatric intensive care unit were safe. This is because there was a culture of reporting incidents, reviewing and learning from them. Staff were able to provide examples of actions taken as a result of incidents being reported. The unit was clean and there was adequate staffing on the day of our inspection.

Care was monitored for effectiveness and scores were within the target range. Plans of care were well documented and updated to reflect the current needs of the children. Parents felt involved in care and there was good team working across disciplines.

Parents reported good experiences of care provided by the service. All staff were described as caring and responsive to the needs of the child. The senior managers were supportive of staff and all levels of staff were aware of the trust's visions and values.

Summary of findings

End of life care

Good

Patients received safe end of life care. Patients who were nearing end of life were identified early so that they could be supported to make decisions about their care. Staff were knowledgeable and experienced in providing care that met patients' needs.

The hospital had actively listened to and took action following feedback from patients and relatives about end of life care. The chaplaincy reflected the cultural diversity of the patients and responded to their individual needs. There was board-level support for the role of the palliative care team and end of life care within the hospital.

Outpatients

Good

We found the outpatients services to be safe. Staff followed correct procedures for the use of personal protective equipment and were aware of emergency procedures.

The hospital was meeting referral-to-treatment time requirements for specialty clinics and audit was used to ensure standards were monitored. We saw people were respected and that their dignity was maintained.

People told us that they felt cared for and thought their care was good. The department was well-led by a visible matron and staff told us they felt supported in their work.

Summary of findings

What people who use the hospital say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust can be seen to be under the England average for the inpatient average component of the test.

Analysis of data from the CQC's Adult Inpatient Survey 2012 shows the trust performed about the same as other trusts in all 10 areas of questioning. The trust performed worse than other trusts on two questions; these related to patients being involved in their discharge from hospital. This information is not broken down to hospital level.

Areas for improvement

Action the hospital MUST take to improve

- The trust must review infection control practices to ensure that patients are protected from cross contamination risks.
- Patients were not protected from the risks associated with unsafe equipment as equipment was found in the medical wards which was dirty.
- People who use services and others were not protected against the risks associated with receiving unsafe care in the clinical decisions unit due to inappropriate admissions from the main A&E site.
- Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients.

Action the hospital SHOULD take to improve

- Communication of the reasons of cancellation and delays in clinics within the outpatient department should be communicated to patients and staff.
- Systems for the transfer of information about medications should be reviewed when patients are transferred from sites that have electronic prescribing so that a full history is available to staff.
- Seating arrangements within the clinical decisions unit should be reviewed as when busy this was often not sufficient.

Good practice

Our inspection team highlighted the following areas of good practice:

- Relatives were involved in patients' care.
- The intensive care unit had a quiet room and a sitting room for relatives. As the unit provides care and treatment for patients who live further afield than Leicestershire, a display screen provided information about the local area, amenities and facilities.
- The trust held a thoracic surgery patient experience day in November 2013 to gather more details about the experiences of patients.
- The discharge lounge was very well organised and well run.
- A specialist cardiac nurse visited the Clinical Decisions Unit to speak to a patient about their options and provided the information the patient needed to make a decision.
- The radiology department offered an open access x-ray service for GP patients. The x-ray was requested online by the GP and the patient could be sent straight in. If the case was judged urgent, results could be ready within two hours.
- The trust has established a network of champions for dementia and older people. These staff had received enhanced training for this role and were visible across the wards and represented in all staff disciplines.

Glenfield Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Mike Anderson, Medical Director, Chelsea and Westminster Hospital NHS Foundation Trust

Head of Hospital Inspections or Team Leader: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission (CQC)

The team of 33 included CQC inspectors and analysts, doctors, nurses, patients and public representatives, Experts by Experience and senior NHS managers.

Background to Glenfield Hospital

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. Glenfield Hospital has 417 beds and provides a range of services which include medical care services for lung cancer and breast care. It is also the base for the trust's heart centre providing treatment for conditions including heart disease. As a teaching trust it works in partnership with several universities including the University of Leicester, Loughborough University and De Montfort University, to provide teaching, research and innovation programmes for doctors, nurses and other healthcare professionals.

We also identified that the trust was consistently above the national average in respect of development of pressure sores grade 3 and above and in catheters and urinary tract infections. We reviewed both these measures while at the trust.

Glenfield Hospital has been inspected twice. The most recent inspection was in November 2012, and the location was found to be compliant with all outcomes that were inspected. Glenfield Hospital had a CQC warning notice served in July 2012. This relates to the governance structures in quality of care provided by the trust. The subsequent inspection found that the trust had taken the necessary actions to comply with the warning notice.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. The trust was chosen for inspection as it was rated as high risk in CQC's new Intelligent Monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner

organisations. The issues raised as part of this risk identification model were: pressures in the A&E department, outliers in maternity, paediatric and general surgery services.

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?

The inspection team always inspects the following core services at each inspection:

- Accident and Emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- End of life care
- Outpatients

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit between 13 and 16 January 2014. During the visit we held focus groups with a range of staff in the hospital: nurses, doctors, physiotherapists, occupational therapists, administrative and clerical staff. We talked with patients and staff from all areas of the hospitals including the wards, theatre, outpatients departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event on 13 January 2014 where patients and members of the public shared their views and experiences of the trust.

Requires improvement

Accident and emergency

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

Information about the service

There is no A&E service at Glenfield Hospital. However, a clinical decisions unit (CDU) provides assessment and initial management of adult cardiac and respiratory emergency patients referred by their GPs, A&E at Leicester Royal Infirmary, or the ambulance service. There is an assessment and triage area. The unit comprises 22 beds and a short-stay ward with 14 beds.

Summary of findings

The Glenfield Hospital does not have a walk-in A&E department. Instead, it has a clinical decisions unit which provides urgent treatment and assessment for patients with respiratory and cardiac health problems. In general, these patients are brought into hospital by ambulance, or referred by their GPs.

Services in the CDU were generally safe and effective, because there were systems in place to identify, investigate and learn from incidents. However, we found that sometimes care was delayed due to the pressure on the service. This meant long waits for treatment at times. Pressures on the department were increased when a divert was in place from the main A&E service and this led to inappropriate admissions to this unit.

Patients were assessed and received treatment that was appropriate to their needs. Patients and their families were involved in their care and given time to think through treatment options.

We saw that care was planned on evidence-based guidelines and staff were receptive to the needs of their patients. However the unit was currently recruiting to the 10 vacant nursing posts. This impacted on the care provided to patients as nursing staff were very busy and could not always attend to people's needs.

The department was well-led with staff feeling supported and able to make decisions.

Requires improvement

Accident and emergency

Are accident and emergency services safe?

Requires improvement

Patients could be referred to the CDU by their GP, by A&E [at Leicester Royal Infirmary] or could be brought in by ambulance. Patients were initially seen and assessed in the triage area. This was a seated area with five trolley bays for assessment. There was inclusion criteria for patients to be admitted to CDU. The ambulance service was aware of these criteria.

Safety and performance

Patients were seen and assessed by a qualified nurse within 15 minutes of arrival. They were then seen by a doctor within one hour. During our visit we saw that patients were seen and treated within these timescales. Staff told us that CDU did become extremely busy and this was a daily occurrence. During these times patients had to wait much longer to be seen and treated.

When the A&E department at the Leicester Royal Infirmary became busy there was a system in place to divert patients to the CDU at Glenfield Hospital. This meant that patients who would normally not meet the usual inclusion criteria would be sent to the CDU. The unit did not usually admit patients over 85 years of age but, when a level one divert was used, this exclusion was removed. A level two divert meant that patients with a wide range of medical problems could be admitted to the unit. We were told that the proper process for diverting patients was not always followed.

Learning and improvement

We spoke with staff about incident reporting. They used an online system to report accidents and incidents. Some staff told us that when they were busy, they would not use the online reporting system. They told us they did receive emailed information and feedback about incidents that had been reported.

Systems, processes and practices

Staff knew what action to take about safeguarding people from abuse and had received training about this. They knew how to recognise the signs of abuse, when to report, and who to report to.

Equipment

We saw that staff were checking equipment such as the cardiac arrest trolley and suction equipment every day. We checked and found that all the necessary equipment was in place and in date. The CDU appeared clean and uncluttered. There were cleaning schedules in place. In line with health and safety guidelines, all staff were bare below the elbow, and they used appropriate protective equipment designed to reduce the risk of cross-infection. There was a good supply of hand-washing materials.

Monitoring safety and responding to risk

We looked at staffing rotas and spoke with staff about staffing numbers. A review was undertaken twice a year to decide the actual number of staff required on each shift. The expected number of staff on each shift was not always met. Staff told us they could be short by as many as four nurses on a shift. They told us that when this was the case the unit did not feel safe. We were told that 10 registered nurses had recently been recruited. They had not yet commenced working on the unit but, once they did, there would still be four registered nurse vacancies. Medical staff we spoke with were also concerned about staffing levels when the unit was busy.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

We spoke with a number of patients and looked at records about the care and treatment provided. The majority of patients reported that they had received the care they required and were kept informed about their treatment plan. Patients were supported to make decisions about their care and treatment. A specialist cardiac nurse visited the unit to speak to a patient about their options and provided the information the patient needed to make a decision.

We saw that all nursing assessments and risk assessments were appropriately completed and management plans were in place. We were told that all patients would be assessed for their risk of developing

Accident and emergency

pressure sores within six hours. We saw that this was achieved and included a visual check of all pressure areas. There was access to specialist mattresses and beds for patients who were assessed as being at risk.

Clinical audits were carried out and the results of audits were displayed on the unit.

Performance, monitoring and improvement of outcomes

The majority of staff we spoke with were aware of the audit programme and able to describe it. Audit results reported that there had been no newly acquired pressure sores, falls or venous thromboembolism (blood clots) for the last period audited.

Staff, equipment and facilities

During our visit we saw that patients were seen and treated in a timely manner. The skill mix for staff on duty was appropriate. Staff told us that access to training was good. All mandatory training was up to date and staff had opportunities for further professional development. We spoke with a recently qualified nurse. They confirmed that a six-month period of preceptorship practical experience and training had been provided. They said they had felt supported during this period.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients brought in by ambulance were taken to the triage area to be booked in. This did not maintain privacy and dignity for patients. Patients waiting in chairs could hear staff during patient handovers. It was also a concern that patients who were very unwell on an ambulance trolley had to wait in full view of the seated patients to be booked by reception staff. We saw that patients were offered drinks and snacks while they were waiting to be seen. Patients in the ward area reported they were happy with the meals provided.

Involvement in care and decision making

We spoke with a number of patients and relatives. The majority told us they were very satisfied with the care and treatment they received. The majority of patients praised the staff and said they had been kept well informed and included in the decision-making process. One patient was very unhappy and told us they did not know the treatment plan or what was going to happen next. We alerted staff to this and they quickly responded and asked the consultant to speak to the patient. We were also told by some patients that the unit was very busy and noisy at night. Some patients told us they had waited a long time when they first arrived on the unit to be seen by a doctor.

Emotional support

We spoke with staff about the action they took to support relatives following bereavement. We were told that written information was provided to relatives and they were given as much time as they needed to spend with the deceased patient.

Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement

Meeting people's needs

The trust provided a service to a diverse population. We spoke with staff about how they communicated with people whose first language was not English. They told us they had access to a telephone interpreter service (Language Line) and that many staff were bilingual or multilingual and could interpret for patients. We spoke with a patient whose first language was not English. They were able to confirm that staff had communicated with them effectively.

Access to services

During our inspection, the seated triage area became very busy. All the chairs were occupied and some relatives did not have anywhere to sit. We were told that, at times, patients could be waiting as long as 10 hours in the triage area. If patients were sent to the CDU from the urgent care centre or from A&E, they would have already waited to be seen there and had to wait again on arrival to CDU.

Requires improvement

Accident and emergency

Leaving hospital

We were told that the long wait for patients in the triage area, after being seen, was predominantly caused by a lack of available beds in the trust. There were three meetings held each day to discuss the availability of beds and improve the management of patient flow in the trust.

Learning from experiences, concerns and complaints

We saw that action plans were developed in response to audit results where concerns were identified. Potential risks to patients such as pressure sores were investigated by the head of nursing and a root cause analysis was carried out. Patients were asked to fill in patient experience questionnaires. The results of these were analysed and displayed in the department.

The CQC's 2012 Adult Inpatient Survey identified a concern around noise levels and lack of privacy for patients. An action plan had been developed and actions were seen to have been delivered However on the day of our inspection we found that the department was noisy and at times patients' privacy was not respected.

Staff had received training about caring for people with dementia. There were also a number of 'older person's champions' appointed to focus on care for the elderly on wards.

Are accident and emergency services well-led?

Good

Leadership and culture

We spoke with staff about leadership in the department. They told us they felt supported by their line managers. Matrons and the head nurses were highly visible and approachable. Staff felt that they all worked as a team and supported each other. Opportunities to de-brief were available. Staff also had access to a counselling service if they needed further support. These opportunities encouraged staff to learn and improve services.

Learning, improvement, innovation and sustainability

We were told that mistakes were responded to in a supportive way and positive action was taken to learn and improve.

Staff were aware of audits taking place in the departments. Results of audits were fed back to staff by email and during staff meetings and handovers.

Good

Medical care (including older people's care)

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

Information about the service

Acute medical services at the trust are provided across three hospital sites and consist of around 36 wards/ departments, 11 of which were at Glenfield hospital.

At Glenfield Hospital, we visited:

- Wards 15, 17, 24, 27, 28, 32 and the coronary care unit
- The discharge lounge.

We spoke with patients, relatives and staff. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

Services for medical care were generally safe and effective and there were systems in place to identify, investigate and learn from incidents. However, we found that sometimes care was not delivered in line with the trust's infection prevention and control policy, which placed people at risk.

Ward staff assessed patients' risks for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients were deteriorating. We found that, although staff were busy, they were available to meet people's needs. However some equipment was found to be dirty, dusty and not regularly checked.

The trust had a dementia strategy in place and there was an active network identified as champions for older patients and those with dementia. This improved care for patients with dementia and enabled early identification of these patients. Initiatives to ensure that discharge was appropriate and timely were having an impact at this hospital.

The wards/departments were generally well-led. Local management set an open culture in which staff felt supported and able to raise issues. The initiatives that had been introduced trust wide were embedded at Glenfield Hospital, these included Listening into action and caring at its best.

Good

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety and performance

It is mandatory for NHS trusts to report all patient safety incidents. An analysis of the trust's reporting revealed that it was reporting incidents as we would expect when compared with other trusts in England. This meant staff were identifying and reporting patient safety incidents appropriately.

The hospital used the Datix patient safety software system to record incidents. Between July 2012 and June 2013, the trust reported 341 safety alerts in medical specialities which accounted for 46% of all incidents at the trust. Staff we spoke with knew how to report incidents and the wards collected data on how many incidents of harm had happened on their ward.

All the wards we visited had safety information prominently displayed for patients and staff to see. The trust rate for new pressure sores was above the national average for between April and August 2013. The trust's performance improved between September and November 2013 and the trend was going down. Each ward we visited collected data on pressure sores and recorded how many days it had been since a patient had developed a new pressure sore. Most wards we visited also had up-to-date information on the number of falls that had happened.

Learning and improvement

We saw evidence that incidents were reviewed and lessons learned from them. For example, on Ward 29 there had been four falls and the matron had conducted a root cause analysis to see if there were any trends. The results had been fed back to staff. This is good practice. Staff we spoke with were aware of learning from incidents in their area. In addition, on Ward 32, it had been identified that checklists to identify whether patients were pregnant prior to undergoing a procedure were not always completed. This had been addressed at a ward meeting and was recorded in the minutes of the meeting. Staff we spoke with were aware of the issue and welcomed the discussion about how to improve care.

Information was shared with staff through emails, bulletins, and staff meetings. Staff all received emails about safety data and received bulletins from the Medicines and Healthcare Products Regulatory Agency and could describe what actions had been taken by the trust. Awareness of the Never Events (mistakes so serious they should never occur) which had happened in the trust was low. Learning from incidents across the different hospitals in the trust needs developing further.

Training rates for life-support training were low and between June and December 2013, 700 spaces were made available for staff to attend in the evening, as staff said it was difficult to be released from the ward during the day. Only 50 spaces on the training had been taken up. Training take-up for acute medical staff was 55% and planned care was 66% with a target of 75% of staff by 31 March 2014.

Systems, processes and practices

Equipment/environment

We saw and staff stated that they had enough equipment to undertake their roles. The hospital appeared clean and clutter free. The hospital is a relatively new build and adequate storage space was available. The layout of the hospital was relatively simple and the trust had put systems in place such as colour coding to enable patients and their relatives to find their way around the hospital. Equipment was maintained appropriately and ward staff reported that faulty equipment was repaired in a reasonable time frame.

Infection control

The trust's infection rates for Clostridium difficile (C. difficile) and MRSA lie within a statistically acceptable range. The hospital had an infection control policy which detailed the precautions needed to minimise the risk of infection. Generally these procedures were being followed. The wards we visited were clean. We saw staff washing their hands and using hand gel appropriately and wearing personal protection equipment such as aprons and gloves. Hand gel was available in all the wards we visited. Patients who had infections were identified and usually nursed in side rooms. On Ward 15, we observed a cleaner using the same cleaning cloth for the tables of all patients in the bay; all had productive coughs. This could spread infection if not used in the correct manner. On Ward 17 we saw that all wall-mounted suction equipment looked dusty, bed areas and lockers looked cluttered with oxygen tubing, masks and the nebuliser kit. When furniture is cluttered, it is more difficult to clean effectively.

Good

Medical care (including older people's care)

Staff we spoke with had a good awareness of capacity assessments and an understanding of when 'deprivation of liberty' safeguards were in patients' best interests according to the Mental Capacity Act 2005. The trust has established a network of champions for dementia and older people. These staff had received enhanced training for this role and were visible across the wards and represented in all staff disciplines. This helped to raise awareness of care for older people and those with dementia in all areas of the hospital and is an example of good practice. Staff we spoke with who were champions were passionate and proud about the role.

Medicines management

We checked how medicines were stored and kept securely and found that this was in line with the trust's policy and national guidance. Medicines reconciliation was done by the pharmacist. However we found one instance where a patient had not received their medicine for two days as it was not available. Staff said they knew how to report errors and incidents and reported that there was learning for those involved, with follow-up emails about learning from incidents.

Staff raised concerns that, when patients were admitted from Leicester Royal Infirmary and had been cared for on wards with electronic prescribing, it was not always easy to access information about their medicines. To address this, the trust had arranged that a print-out of current treatment was sent with the patient. This print-out did not include past medicines. Also, as electronic prescribing had not been rolled out across the trust, there were sometimes delays in finding staff who could access the electronic system and this led to problems finding out when a patient had last had analgesia (painkillers), for example.

Resuscitation equipment

We looked at the emergency trolleys when we visited Wards 15 and 17. On both wards the trolleys were dusty and in Ward 17 there was fluid in the chamber of the suction machine. This was an infection risk. We found that, in some cases, trolleys were overfull which could make it difficult to access equipment in an emergency. Of the three trolleys we looked at, all had equipment missing which should have been in the trolley.

Records showed that resuscitation trolleys were checked regularly but the issues we found had not been identified. There was no standardisation of trolleys, which meant that there were different trolleys across the hospital. This can lead to a delay in being able to find equipment quickly. A rota is published daily at Glenfield Hospital, which identifies members of the cardiac arrest team. The resuscitation officer agreed that cardiac arrest trolleys should be standardised across the trust to a 5-drawer cardiac arrest trolley and this would be a forthcoming agenda item to be discussed by the resuscitation committee as part of a programme of work for the coming year.

Monitoring safety and responding to risk

There was a high level of vacancies on the wards we visited. The trust told us that they had recently recruited 250 staff but needed another 250 staff to fill all the nursing vacancies. Staff commented positively on the improved recruitment processes which resulted in faster appointments.

Ward 24 had been recently changed to care for both cardiology and respiratory patients, whereas previously it had only cared for cardiology patients. Some staff were experienced in respiratory care. The senior sister had identified that some staff needed further training in this area and had arranged for it to be provided. As part of the move, the number of beds had increased. The decision had been made in October 2013 as part of the trust's plan to relieve pressure on beds.

The trust had been trying to recruit staff to fill the current vacancies. Two staff nurses were due to start but the other vacancies remained. The hospital used agency nurses to plug the gaps. They tried to use the same staff each time for consistency of care for patients, but this was not always possible. When agency staff were not available, in-house staff working on the ward covered shifts with overtime which meant that some were working very long hours with few days off. The senior sister said she was very proud of how her team had managed the changes. We found that there was little impact on patient care as sufficient nurses were on duty to meet their needs.

Ward 32 had recently recruited staff and currently had three vacancies. A senior healthcare assistant role had been created, with enhanced training available to allow a healthcare assistant to develop into the role. This person took on some of the procedures from qualified staff and was seen as a very valuable member of the team. The senior healthcare assistant remained at all times under the supervision of a nurse.

Good

Medical care (including older people's care)

We met with staff from allied health professionals such as physiotherapy, occupational therapy and pharmacy staff who reported that there were also vacancies in these staff groups. They commented that, when ward changes were made, (such as those on Ward 24), this impacted on their work, but they were not always informed in advance, making it more difficult to manage the increased workload.

Anticipation and planning

The trust had systems in place to monitor how it performed against a number of key safety performance indicators. These systems were embedded on the ward. All staff we spoke with told us that they received emails to communicate any changes. Where emails were considered important, these were printed off and displayed for staff to see. Important information was shared via staff meetings and at patient handover.

The trust had plans for emergency situations such as norovirus and flu outbreaks.

On all wards we visited there were safety metrics displayed, which showed how safe the care was to patients and their families as well as trust staff.

Are medical care services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

Glenfield Hospital is nationally recognised for heart disease, lung cancer and breast care. The hospital works with the two universities in Leicester to promote research into heart disease and cardio respiratory disease. We saw that NICE guidance was in place in respect of these services.

According to the Myocardial Ischemia National Audit Project (MINAP) data for 2011-2012 Glenfield Hospital was performing as expected in four of the five indicators and tending towards better than expected for the last indicator. The trust continued to monitor this through local audits.

Performance, monitoring and improvement of outcomes

There was an operational policy in place on the discharge lounge which described how the lounge would be run and what types of patients it would accept. The policy was due for review on September 2013. Parts of the document had been highlighted as needing to change. The policy detailed how to escalate issues when patients had to wait a long time and when incidents were to be reported via the Datix system. There were several omissions in the operational policy, for example it did not explain what staff should do if patients were admitted but should have been excluded according to the criteria, discharged after the unit's closing time or discharged in breach of the trust guidelines for discharging to care homes (i.e. out of hours).

The operational policy stated that one of the ways it would measure effectiveness would be by number of Datix incidents reported. There was a danger that incidents may not be recognised or reported as they had been omitted from the policy.

Staff, equipment and facilities

The trust had an induction programme for staff joining the trust. There were also local induction programmes to support the trust induction programme. Staff told us that, where agency staff were needed, they tried to use the same personnel to ensure continuity for patients. Matrons were able to describe how they managed poor performance.

There were link nurses identified for a number of roles on wards, including dementia and infection control. These nurses took on an enhanced role to improve practice on the ward. However, there were no link nurses for resuscitation.

There was an extensive network across staff groups of champions for elderly and dementia patients. These personnel were very passionate about providing good care to people and were very visible around the hospital. They had received enhanced training in the care of people with dementia and were skilled in communicating with those who were not able to verbally express their needs.

Ward 32 had arranged for staff to have training from colleagues working in the catheter laboratory to enhance their knowledge and understanding.

Multidisciplinary working and support

We saw evidence that multidisciplinary teams worked effectively together to provide care for patients. We saw examples where patients' family wishes had been respected – for example, when a relative requested that a

Good

Medical care (including older people's care)

patient be kept on the ward rather than wait in the discharge lounge, this had been arranged. Patients were generally looked after on the appropriate ward for their needs.

Are medical care services caring?

Good

Compassion, dignity and empathy

The trust has consistently scored below the England average for the Inpatient Friends and Family test from July 2013 onwards. At this site two wards were identified as being below the trusts average score. These were ward 20 and the clinical decisions unit. However on review of the number of patients who answered the questionnaire most respondents (27 out of 31 and 94 out of 114 respectively) would recommend their friends and family to these areas.

Curtain clips were used throughout the wards to ensure that patient dignity was maintained and we saw that staff always checked before entering.

Involvement in care and decision making

When we spoke with patients and family, they were all very positive about their stay in the hospital and the care they had received. They told us they felt involved and that doctors had explained to them about their care and treatment. Where patients lacked capacity to make decisions, we found that appropriate assessments had been made.

Patients knew which staff were looking after them for the day. At our listening event, people raised concerns that communication with doctors and nurses was poor. When we visited, patients told us that staff talked to them about their care. Patients were able to tell us what was happening with their treatment and when they were likely to be going home. When we spoke with staff, they were able to tell us about patients' needs and how they were being cared for.

Trust and communication

We observed the care being provided on the wards we visited. We saw that staff introduced themselves and were kind and caring when looking after patients. Although staff were very busy, they did not rush patients and people looked very well cared for. Patients told us that they sometimes they had to wait for a nurse to respond to a call when there were staff shortages, but they felt that: "staff went the extra mile" to care for them. Patients were treated with respect and notes were respectfully written. Patients' care plans were up to date and risk assessments were updated and reflected current need. Care was being delivered which met the identified needs.

Patients told us that their pain was well controlled and felt they could say if they were in pain and action would be taken. Patients said that they were kept informed about any new medicines prescribed or any changes to their treatment. There were policies for respecting patient decisions about their care. Staff we spoke with knew the resuscitation status of patients.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

We met with trust staff to discuss how they had planned care for patients with dementia. Hospital staff had met with community groups to find out about their experiences and needs.

The trust had a dementia strategy in place and there was an active network identified as champions for older patients and those with dementia. These staff wore badges to identify them and received extra training to support patients and colleagues throughout the hospital. Champions were from all staff groups: administration, nurses, doctors, porters and allied health professionals. Champions we spoke with were very passionate about their role and helped improve care for these patient groups throughout the hospital.

Access to services

In Leicester, 36% of the population belong to minority ethnic groups. Three main languages other than English were identified as being spoken by patients. Signs around the hospital were only in English; there were none in other languages.

The trust was planning the introduction of electronic surveys which would be available in a range of languages. There was a 24-hour translation service on all wards which

staff knew how to access. Information leaflets were available on all wards. Not all wards stocked leaflets in other languages, but staff knew how to access them if needed.

The radiology department offered an open access x-ray service for GP patients. They were seeing between 160 and 170 patients a day. The x-ray was requested online by the GP and the patient could be sent straight in. If the case was judged urgent, results could be ready within two hours. The department had good links with the A&E department at Leicester Royal Infirmary so could transfer patients if treatment was needed.

Leaving hospital

In order to improve patient flow through the hospital, a new meeting had been instigated which included clinicians. There were a range of meetings throughout the day which monitored the availability of beds and identified any problems which might delay discharge, such as a delay in supply of medicines for the patient to take home.

The trust had undertaken work to improve the patient flow through the hospital. For example, to improve flow from the clinical decision unit, the trust had set up a number of initiatives, including a discharge lounge. The discharge lounge had a dedicated pharmacy technician to help reduce delays with the supply of medication. The patients and families we spoke with were informed and included in their discharge. There were policies in place for the safe discharge of patients which described times after which patients would not be discharged to care homes and community hospitals.

We visited the discharge lounge which looked after patients who were assessed as medically fit for discharge but were waiting for final arrangements such as medicines.

The discharge lounge had leaflets which explained its purpose and what patients could expect. It was very well organised and well run. There was an 'assessment for admission' checklist and, when we visited, appropriate patients were being cared for. Staff on the discharge lounge told us that they aimed for patients to be on the unit for less than two hours. Staff monitored discharges very closely and, if there had been a delay which meant it was not safe for them to go home, then the patient would not be discharged. Patients we spoke with on the discharge lounge were happy with the care they received.

Learning from experiences, concerns and complaints

The trust had effective systems in place to gather information from service users, and had gathered information about people's experience from more than 4,000 patient surveys. This was being used to improve care, for example, addressing delays in answering call bells. From feedback the trust has received for areas for improvement and they added questions to the survey so that they could monitor that actions they had taken were effective.

There were Message to Matron postcards on all the wards we visited where patients could give feedback on areas for praise and concern. These were monitored by the matrons and fed back to ward staff to drive improvement. Patient complaints were monitored as part of the ward metrics and staff were aware of them and actions taken to address them. Patients knew how to raise concerns and complaints with staff and were confident that they would be dealt with.

Two years earlier, the trust had been told that patients from non-English speaking communities were not filling out surveys as they felt no action would be taken. Trust staff had gone out in to the community to meet with patient groups. The most common theme was about food as the Asian community did not trust that food had been sourced or prepared appropriately. In response, the trust had outsourced common Asian dishes from a local provider from the Asian community.

The trust had held a workshop in the autumn of 2013 on 'Improving Experience for Patients and Staff' to examine the different ways people communicated and received information. The response was positive and the trust have begun to implement some of the actions raised by patients their families and friends.

Are medical care services well-led?

Good

Vision, strategy and risks

The trust had a published vision and most wards we visited had their own vision. Staff we spoke with knew the trust values and were proud to work at the trust. Staff were passionate about their work and said that they had seen improvements since the changes in executive leadership.

Good

Medical care (including older people's care)

The chief executive was very visible. Staff said he sent regular emails and held breakfast meetings which staff of all levels told us they had attended. Staff also spoke positively of the Listening into Action programme which aimed to engage teams in producing quality outcomes.

Nursing staff told us that the recently appointed chief nurse was very visible and commented positively on the fact that she was often seen on the wards in uniform. On Ward 27 we saw the chief nurse's briefing letter on the wall.

Leadership and culture

Wards were very well-led with ward sisters being very involved in setting the culture of the wards. The staff we met were very dedicated and working very hard to provide good care. Staff told us they had training and appraisals. Newly qualified staff were supported with preceptorship. At ward level, staff told us they felt very well supported by matrons. Staff were very committed to providing good care.

When we met with allied health professionals, the physiotherapists and occupational therapists told us of the changes that had happened in their management structure. There were differing views on how well the changes had been implemented. Staff were very positive about the teams they worked in and their management.

Staff told us that the culture of the trust had improved and that they now felt able to raise concerns and were more confident that they would be listened to. Staff were aware of the risks to patients in the area and how the trust was monitoring them and actions taken to mitigate them. On all the wards we visited, staff reported that they were very well supported by their managers. Doctors in training told us they felt well-led and supported.

Good

Surgery

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

Information about the service

Glenfield Hospital provides 71 bed spaces at this location for elective surgery.

The surgical department last year saw 22,000 inpatients and 81,000 day-case patients across the trust. This location provides elective and emergency surgery. Surgery provided at this location includes cardiac surgery (both adult and paediatric), thoracic (chest disease) surgery, general surgery and the Breast Care Centre.

During our inspection, we visited four wards: wards 23a, 26, 31, 34.

Summary of findings

Surgical services at Glenfield Hospital were safe and staff knew how to report incidents and action was taken as a result of these. However staff reporting these incidents did not always receive feedback about the incident that they had reported. National guidelines are followed by staff to ensure that patients are safe when undergoing their operations. However risk assessments for thrombosis and pressure sores were not always undertaken which led to increasing incidents at this location.

We found that staffing levels were, overall, much more stable at this location but did not always meet the trust's agreed levels. We found that national guidance was not always followed and this posed a risk to patients. Patients experienced a number of transfers between wards at this site which led to a poor patient experience.

We found that the provision of care was well-led and that leadership was robust. Staff felt that communication had improved, management was more cohesive and accessible and the culture of the hospital was good with positive changes to senior management structures and governance.

Good

Surgery

Are surgery services safe?

Good

Safety and performance

The trust reported three Never Events (classified as such because they are so serious that they should never happen) between 1 December 2012 and 31 November 2013. None of these events occurred at Glenfield Hospital.

Data we received before the inspection indicated that there may be a lack of understanding of incident reporting procedure. We discussed incident reporting, including reporting safeguarding issues, with all staff interviewed. All clinical staff we spoke with were aware of the Datix patient safety reporting system and were confident to report any incidents they deemed necessary. Staff felt that they were not always advised of the lessons learnt from these incidents.

Learning and improvement

A ward matron told us that, while they had undertaken investigations following reported incidents, they did not always receive feedback, but the Datix software did help to identify trends. They felt that feedback to staff was very important for learning.

A registrar said he knew the benefits of reporting incidents but that junior doctors were not taught about clinical governance so had to pick it up as they progressed. They were encouraged by all staff to report incidents. However, medical staff stated that feedback was rarely given to the reporter and this meant they were reluctant to report. We were informed that incident reporting was promoted within wards and other departments; however, we were informed that feedback was given to ward sisters or matrons only. Matrons were then responsible for disseminating information as required, but this was not always happening.

We saw pre- and peri-anaesthetic care plans and safer surgery checklists which were completed before surgery and before returning to the wards, (these include all relevant risk assessments) which had been reviewed post op.

Systems, processes and practices

Equipment

We saw defibrillator machines in each ward we visited and noted that routine checks were completed on the equipment and signed for. We noted on one ward that the trolley did not have a suitable security red tag and were told that this was being addressed. We found evidence of an electrocardiogram not working in one ward, resulting in tests being delayed and staff having to borrow equipment from other wards. This had been escalated but not actioned.

Infection control

We were informed that infection control teams and tissue viability teams were set up in the trust and accessible at Glenfield Hospital. Part of this inspection included a focus group with the infection control team members. We saw evidence in patients' pre- and post-operative records of relevant blood testing and MRSA screening. The trust's infection rates for Clostridium difficile (C. difficile) and MRSA lie within a statistically acceptable range.

We observed hand hygiene procedures in ward and theatres areas. We noted that, although appropriate equipment, including hand-washing material and anti-bacterial gels, were provided, some staff were observed to not follow correct hand hygiene procedures, including not washing their hands after helping patients. We observed poor infection control in one ward where water jugs were being filled from hand-washing sinks. In one area we noted that mattresses were being stored in a ward corridor.

Monitoring safety and responding to risk

We reviewed data from the NHS Safety Thermometer (a tool developed to help frontline staff measure risk) which showed that the trust was performing at a similar level to others in England. The rate of falls at the trust had dropped since the trust introduced new systems. The number of pressure sores was rising; however, this is being addressed by the chief nurse who was reviewing remedial plans with the senior nursing team. Staff informed us that they had implemented the 'Best Shot' initiative; this involved a nominated person undertaking visual inspection of all pressure areas and reviewing risk assessments at least twice daily. We were informed that recent incidences of

pressure sores could have been attributed to inaccurate risk assessments being completed and scoring being wrong. Teaching sessions have been arranged to update staff skills.

Since November 2013 the venous thromboembolism (VTE) or blood clot rates have increased to above the England average. To ensure patient safety, the department included the VTE care pathway. We were provided with the trust policy and we found on the wards we visited that all the patients were assessed for their risk of VTE at the pre-admission clinic and immediately after surgery. Staff told us that rates could be improved and that, because medical teams changed frequently, ward clerks were now inputting records onto the IT system. A newly qualified nurse told us that it was unclear who held responsibility for recording VTE assessments and on which documentation.

All stages of the World Health Organization (WHO) surgical safety checklist were completed in documentation we saw.

We reviewed patients' notes and observed practice during the visit and noted that elective surgery incorporated discharge planning, including mobilisation from the third day after surgery. We found that all documentation included falls risk assessments. Matrons told us that falls validation has confirmed that all falls assessed were unavoidable. We saw the international nurses' induction programme which includes a training session on management of falls in week four of the programme to ensure that new starters were aware of the assessment of falls risks and reporting mechanism.

Staffing

The ward staff told us that staffing was less of an issue at Glenfield Hospital possibly because most of the surgery was elective, which meant that wards were able to plan more. However, on one ward, a ward sister expressed concern at the number of whole time equivalent staff on long-term sickness or maternity leave. They raised concerns regarding external recruitment where they were not involved. We were told that it was "of concern because we need to be sure of the competency and skills of staff appointed. This is a very specialist area where we cannot just use random agency staff".

We saw evidence of good practice for staffing on a number of wards. We were informed that staff were, where possible, moved only within their own service, skills and experience, although, when shortages occurred, they could be moved anywhere in the hospital. We noted on a number of wards that staffing levels and recruitment of staff was problematic. The trust had implemented a new electronic rostering system designed to ensure full coverage on shifts. However, this system had caused some problems with staff being rostered to work five straight, 12-hour shifts. Staff were very flexible and showed goodwill when filling additional shifts. Staff were moved from ward to ward where needed.

Medicines management

Pharmacy technicians work full time in the discharge lounge at Glenfield Hospital to provide access to take-home medications and patient counselling so patients know how to take medicines when they get home. The trust has produced patient information leaflets on this topic. Concerns were raised in a focus group about the skill mix in pharmacy. This was discussed with the acting chief pharmacist and we were assured about the mix of skills in this department. We saw appropriate amounts of patient controlled analgesia and intravenous therapy machinery on surgical wards we visited.

Staff said that access to medicines could be an issue in delaying discharge, especially after 6pm when site pharmacy was closed and medications had to come from the Leicester Royal Infirmary.

Anticipation and planning

We saw two initiatives in the Breast Care Centre which included an overnight stay information pack designed by the ward manager for patients who need to stay in longer than the 23-hour discharge pathway. This is provided to staff on other wards to ensure continuity of care when a patient is transferred overnight or over a weekend when the unit is closed.

Are surgery services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

NICE guidance was evident throughout the surgical service at Glenfield Hospital. The cardiac centre at the hospital is leading the way in developing new techniques such as the

Robotic Arm, TAVI (Trans-Catheter Aortic valve Insertion) the sutureless valve in heart surgery. Patients who undergo aneurysm repair survive longer at Glenfield hospital than is usually expected.

Performance, monitoring and improvement of outcomes

The trust developed a Caring at its Best strategy. We found evidence of this on all wards and staff we spoke with were fully aware of it. Staff were working hard to achieve the targets set by the trust for completion of questionnaires and we saw an action plan for the Message to Matron postcards which patients use to give feedback and comments.

Patients knew how to make a complaint and had been given information in pre-admission documentation.

Trust protocols were implemented to improve discharge arrangements for day surgery in specific wards, including a 23-hour care pathway in the Breast Care Centre and a 'Going home with a redivac drain after breast surgery' advice sheet to help patients going home after surgery. The ward runs a daily 'drains and dressings' clinic, providing good post-operative patient support. This was well received by some patients.

A matron informed us that, as part of the auditing system, senior management now conducted a quality and safety walk around the wards each month to observe staff and talk to relatives and patients. Another matron told us that she was confident in her own staff reporting incidents and that the system allowed her to look at trends and give feedback to staff.

Staff, equipment and facilities

We found that, overall, staffing levels on wards were safe and all wards we visited talked about "great team dynamics, team working and multidisciplinary team working". However, in some areas we found that staffing levels was affecting the way care was delivered. Two ward sisters told us they could not authorise any agency staff and one said they were filling gaps with overtime. We were told that, to manage the needs of patients, shifts had been reorganised and staff deployed to different areas where required, for example, when ward activity was at its busiest. We saw evidence of staff being moved around within the service, ensuring continuity of staff skills for patients.

A ward sister told us that they did not use agency staff generally because of the specialist nature of the ward, but that there were no real concerns about staffing. She said that the team was cohesive and that morale on the ward was very good. There was an internal recruitment drive which had resulted in new staff being recruited. Senior ward sisters and matrons informed us that appointments were often delayed due to lengthy human resources processes and that recruitment was typically poor at this location.

We reviewed the sickness policy as there had been some indication from the staff survey that staff felt they had to return quickly to work after being off sick. During our discussions with staff we found no evidence of this. The policy has strict timescales which staff were aware of regarding when a manager may call or visit them.

Staff on wards told us about their experiences of training. Most clinical nursing staff told us they had time to do mandatory training and had been given an e-learning account which they could either access from home or complete at work during less-busy periods. Most staff told us they had completed mandatory training. A number of staff said they had completed safeguarding and dementia training. It was apparent from discussions that they were responsible for completing the training.

Ward managers told us they could access their own staff's e-learning account and could analyse individual training records to ensure staff were completing the required training. One ward sister told us she had also designed her own spreadsheet to keep up to date. Concerns were raised regarding the training that agency nurses have. Senior staff informed us that new induction training was now being provided for all bank staff. We heard evidence from senior staff that monthly teaching for band 6 and 7 staff was being provided to improve management skills.

A junior doctor told us they were supported to learn, and during wards rounds were questioned by consultants before undertaking procedures. They confirmed they were never asked or forced to do anything outside their range of competency. The doctor told us that there was agreed study leave for those in training and that consultants adjusted their schedules to ensure that training was completed in line with General Medical Council (GMC) training guidelines.

We received information prior to the inspection regarding the incorrect removal of a patient controlled analgesia infusion pump following surgery. We found no evidence of

this in any data (including NHS Choices reviews). Pain relief was assessed by pain nurses and reviewed as necessary. Nursing staff told us that the analgesia pumps could sometimes hinder recovery and mobilisation, But that they were not removed unnecessarily and not if needed by patients.

Multidisciplinary working and support

We found evidence of multidisciplinary team working in all areas we inspected. We saw records of patients admitted for surgery which demonstrated good multidisciplinary input. We observed a team handover on one occasion which included the discharge coordinator, physiotherapy, and occupational therapist plus nursing staff. These discussions included evidence of how the team were working with external providers and the social work teams to ensure safe discharge.

Are surgery services caring?

Good

Compassion, dignity and empathy

The NHS Friends and Family Test asks patients whether they would recommend the hospital wards to the friends or family if they needed similar care. Response rates for the trust were below the national average. Glenfield Hospital scored well in the test and no wards at this hospital were identified by respondents that would not be recommended.

We received many comments from patients and relatives regarding both clinical and medical staff over the time of the inspection. By talking to patients and relatives, we found that they were mainly all very positive about their own experiences of being on the ward. We found no evidence of any recent complaints and only one concern over use of male staff at night time. This could not be further investigated with the patient as it was an anonymous comment.

We were told by a number of patients and relatives that staff were responsive to their needs and were kind and caring. We saw evidence of a specialist surgical ward having protected mealtime arrangements and achieving the quality and service award 2010. We observed good patient interactions on wards and patients told us that staff delivered care sensitively and in a caring manner. On a thoracic ward for the surgical treatment of chest diseases, a patient told us that staff responded in a timely manner to any requests, including for pain relief.

Involvement in care and decision making

We found that pre-operative assessments (green for go) were carried out and care planned in consultation with patients. We found that consent to surgery had been obtained from patients at pre-assessment clinics and patients fully understood the procedures they had signed for. Patient files reviewed included activities of daily living assessments, including falls, nutritional and thrombosis risk assessments. Consideration of cultural needs and choices were included in pre-operative assessments seen.

Trust and communication

The NHS Choices website has 231 reviews for Glenfield Hospital, with an overall score of 4.5 out of 5 stars of which 30 comments rated 5 stars, including excellent care, good communication, staff helpfulness, cleanliness and good food. There were 28 comments in the review about lack of staff, cancelled lists, unhelpful or rude staff. The location scored 100% in Patient-Led Assessments of the Care Environment (PLACE) in 2013. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

Emotional support

We noted that, in the Breast Care Centre, staff provided physical, emotional and social support to patients recovering from breast surgery. Further support was provided by counsellors, breast care nurses from the East Midlands Cancer Network and also external groups such as the breast cancer charity, Bosom Buddies UK. This meant that patients were fully supported throughout their patient journey. Patients described the service in this ward as “first class”.

Good

Surgery

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

We were provided with information about a recent patient experience day in November 2013 which was provided to determine the views of the patient experience for thoracic surgery patients. This was the third held within this service. It was developed and facilitated by the ward managers, nurses, healthcare assistants and a consultant. Findings were identified and categorised as strengths and weaknesses in areas such as communication privacy and dignity, hospital facilities and the environment, patient journey. An action plan was completed in December 2013.

The trust also introduced the Listening into Action initiative to improve the patient experience; this was evidenced while in discussions with senior staff on wards and in focus group discussions.

Leaving hospital

We reviewed the discharge arrangements for patients as the CQC's Adult Inpatient Survey 2012 showed an upward trend in delayed discharge and patients not being involved in decisions about discharge. Some ward staff commented on the trust's discharge policy which has a target of discharge before 11.00am, driven by bed availability. We were informed that, in accordance with the policy, matrons and ward managers attended meetings every morning to discuss the day's discharges and bed availability. Concerns were raised with us by nursing staff over the discharge of elderly confused patients into the discharge lounge where there was limited bed availability. Staff were also worried about excessive movement to other wards, occasionally in excess of three times per patient stay, which is unsettling for patients.

We were informed that this location undertook elective and emergency surgery. The pressure to discharge was less problematic and was more structured. We were told that, on surgical wards, patients were discharged directly from the wards. A number of wards have designated discharge nurses in place and their role is to manage complex discharges which includes management of potential safeguarding. We were given an example of a potentially unsafe discharge involving a patient with complex needs. Evidence provided demonstrated that a multidisciplinary team approach was used, calling on relevant professionals to ensure the safety of the patient returning home.

We noted that some wards were closed at night and over weekends. Some concerns were expressed to us about delayed discharge of post-operative patients who were transferred to other wards where the ward speciality was different. We were informed that a member of the staff team on a specialist ward worked at weekends to ensure safe discharges for those patients.

Learning from experiences, concerns and complaints

Patients told us they had been alerted to the NHS Friends and Family Surveys (leaflets and website) and understood the need to monitor the quality of the service. We saw the Caring at its Best questionnaires on a number of wards and additionally we saw Message to Matron comments postcards available for patients and relatives to record their comments. We reviewed the last month's matron's comments audit and saw that concerns raised were addressed. We saw evidence in all wards and associated areas of how to make a complaint, and patients told us they were aware of the process. We noted that comments cards did not include a space for the person to add their contact details should they wish to discuss their concerns and receive feedback.

The trust has also introduced the Listening into Action strategy to improve the patient experience, and this was evidenced while in discussions with senior ward staff in our focus group discussions. We saw good evidence of patients' views being considered in the patient experience day held in November 2013.

Are surgery services well-led?

Good

Vision, strategy and risks

We received very positive feedback about the vision of the new chief executive officer and chief nurse from all nursing and medical staff we interviewed, describing them as "visible" and "inspiring." We were told that both are focused on quality and give good feedback on trust performance.

Good

Surgery

We were also informed that the chief executive was very visible, making himself available for staff discussion at the Breakfast with the Boss meetings and open to receiving emails. Clinical staff told us that they considered information was disseminated well from the senior team and was well received.

We were told that staff morale appeared to be improving since the new appointments and that a 'no blame' culture now existed. One member of staff said, "They make us feel important. I'm really proud to work here". Staff informed us that the restructure of the clinical management group had improved communication and was flatter and more accessible.

Governance arrangements

We were informed by senior nursing staff that there is a monthly briefing on site, attended by all senior nursing staff; staff are expected to attend. Also that the flatter clinical management structure had improved the way issues were escalated and managed.

Leadership and culture

We found that leadership was mostly very good at this location and saw evidence of good communication systems, including newsletters produced by the ward sister to alert staff to changes and day-to-day issues. These were emailed to staff if they were off sick or on maternity leave to ensure that they remained in touch with changes.

Patient experiences, staff involvement and engagement

The staff survey, undertaken by CQC in 2013, indicated that the percentage of staff reporting good communication between themselves and senior managers had gone down from 27% to 22%. Other areas where the trust performed less well include team working, communication with management and pressure felt by staff to attend work when unwell. We reviewed this at our inspection and found that, since the appointment of the new chief executive, staff felt they were kept informed. The survey was undertaken early in 2013. For example, staff told us that there had been changes to the nurse to bed ratios, increases in nursing posts advertised and that ward managers were now allocated two days per week for supervision. Further improvements include a strong focus on managing the prevalence of pressure ulcers and falls.

The trust's sickness absence rates and agency staff spending are both lower than those for the East Midlands Strategic Health Authority. This indicates that the trust does not have serious issues with staff sickness. The results of the 2012 NHS Staff Survey indicated that the trust is performing well regarding staff appraisals, staff witnessing and reporting harmful incidents and general staff satisfaction. We saw written evidence of staff receiving routine supervision and annual appraisals. Staff told us that they received at least an annual appraisal but, in some areas, one-to-one supervision was less formal. We noted on a number of wards that staff training and deployment was highlighted on staff rotas.

Learning, improvement, innovation and sustainability

Staff on wards and in theatres told us about the availability of, and their experience of training. Most clinical nursing staff we spoke to told us they had time to do mandatory training and had been given an e-learning account which they could either access from home or could do at work during less busy periods. Most staff told us they had completed mandatory training. A number of staff told us they had completed safeguarding and dementia training. It was apparent from our discussions that they were responsible for their own completion dates. Ward managers told us they can access the e-learning account and analyse training records to ensure that staff were completing the required training.

Good

Intensive/critical care

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

Information about the service

The critical care service at Glenfield Hospital has 22 beds in the intensive care unit (ICU), delivering care to adult patients with life-threatening illness. In addition to this, there are 17 high dependency unit (HDU) beds, located on another ward within the hospital, for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital.

We talked to one patient and 18 staff, including nurses, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients received safe, effective and responsive critical care services. There were enough specialist staff to meet people's needs and ensure that they had appropriate, 24-hour support. People received care and treatment according to national guidelines and admissions were prompt and appropriate.

There was always sufficient equipment available to meet to the needs of the patients. Patients' medications were stored securely and were within their expiry dates. The ICU was visibly clean and well-maintained. There was an adequate amount of space, particularly between each patient's beds. Patients had either one-to-one nursing, or one nurse to two patients. Patients were supported to make decisions about their care, where possible, and relatives were involved in their family member's care.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

The service was focused on safety. Each member of staff we spoke with confirmed they knew how to report incidents using the trust's electronic system. The matron confirmed that incidents were analysed by senior clinical staff and appropriate specialists recommended improvements. We were told that one incident had been re-enacted (simulated) to look at how lessons could be learned. Staff told us that they received feedback from the incidents they reported, both individually and in ward meetings.

Systems, processes and practices

Patients' welfare was regularly monitored to ensure that changes were responded to in a timely manner. There were sufficient senior doctors at night to ensure that patients' health did not deteriorate out of hours. A critical care outreach team provided a 24-hour, seven-days-a-week service across Glenfield Hospital. This team assisted in the management of critically ill patients on wards across the hospital. The trust used an early warning system to help identify when a patient's physical health was deteriorating so that appropriate action could be taken.

We were informed that consultant cover for the ICU was in line with the national ICU guidance. However, there were some gaps in the junior doctor rotas. At times when there were shortages, consultants would "act down" to cover the shortfall. We were told that there was a business plan in process to increase the medical workforce in the ICU.

Equipment/environment

Staff reported, and we saw, that there was always a sufficient amount of equipment available to meet to the needs of the patients. We spoke with a member of staff responsible for managing the equipment and discussed the stock management system. The system included monitoring the expiry date of disposable equipment. We saw that equipment was serviced at regular intervals and in line with the manufacturer's instructions. The emergency resuscitation trolley contained all the equipment necessary to deal with a medical emergency, and was checked twice a day. The contents of the trolley matched the contents detailed on the checklist. We saw records of these checks, confirming what we had been told.

During our visit we undertook a tour of the ICU. We saw that there was sufficient space, particularly between each patient's bed. This meant that the department was meeting the national standards for ICUs. We saw there was adequate storage facilities for equipment and supplies that were not being currently used.

Medicines management

When we checked the medications in the ICU, we saw that patients' medications were stored securely and were within their expiry date. We saw that medication was stored appropriately and that storage facilities such as fridges were monitored to ensure the effectiveness of the medication. Medicines were kept secure and records kept of their use.

Infection control

We saw that the ICU was visibly clean and well-maintained. We saw there were sinks between each bed and we found that infection rates were low. Patients were cared for in a clean environment with clean equipment. Hand hygiene gel was available at the entrance and exit of the units. Staff members were observed wearing appropriate personal protective equipment, including gloves and aprons. We saw staff washing their hands before leaving the units and between assisting patients. Pedal bins and sharps bins were available for waste disposal. We saw there were cleaning schedules which included the frequency and detail of the tasks performed. We reviewed the comprehensive infection prevention and control policies. We observed and spoke with staff that were able to demonstrate their awareness and knowledge of these policies, and confirmed they had training in relation to infection control and prevention.

We saw appropriate risk assessments had been completed in relation to intravenous lines and urinary catheters. The latest Intensive Care National Audit & Research Centre (ICNARC) report for 2012/13 shows that the trust is performing below the national average for rates of MRSA. This is a positive indicator of infection control practices within the unit.

Monitoring safety and responding to risk

There were enough appropriately trained staff to meet patients' specialist needs. We were told that a number of staff vacancies currently existed, though many of the vacant positions had been recruited to, following an international recruitment drive. This resulted in some staff being recruited with less experience and training in ICU

nursing. However we saw a comprehensive and structured eight-week induction programme for new staff joining the ICU. In addition. We were told that each new member of staff had a mentor (a more experienced nurse) to assess the individual's performance, skills and provide ongoing training and development. The matron told us that the National Competency Framework for Adult Critical Care Nurses was used in the ICU. These competencies provided a framework for staff training and development within ICU nursing. The staff we spoke with confirmed they had regular one-to-one meetings with a senior member of staff, and received an annual appraisal.

Patients had either one-to-one nursing, or one nurse to two patients. If these ratios could not be maintained then the unit had a policy to bring in staff from other ICU's provided by University Hospitals of Leicester NHS Trust to ensure that emergency patients could be admitted. The unit did not admit any more patients if a safe level of nursing care could not be assured. We were told and found that the ICU worked towards the national standards for staffing in ICUs.

Anticipation and planning

We saw the ICU had a comprehensive business continuity plan which gave details about how patients' care would continue to be provided in the event of an emergency situation. Such situations included, for example, an electricity power cut, or disruption to the supply of medical gases. This told us that contingency arrangements were in place in the event of an emergency.

Are intensive/critical services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

The latest ICNARC report shows that the trust are performing within expectations and below the average (in this situation, preferable results) for: unit-acquired MRSA, out-of-hours discharges to the ward, delayed discharges (four-hour delay) and unplanned readmissions within 48 hours. However, the trust is performing within expectations but above the average for: hospital mortality and non-clinical transfers (out). We were able to corroborate some of this information at our inspection.

We were told how patients were supported to make decisions about their care. Due to the nature of patients' conditions in the ICU, it was explained that if the patient was unable to provide consent, treatment would be provided in their best interests. Staff were aware of the need to comply with the Mental Capacity Act 2005.

We saw a range of risk assessments relating to patients' basic needs. These included, for example, assessing the risks in relation to pressure and skin integrity care, the use of bed rails, falls and nutritional needs. The risk assessments were appropriately completed and kept up to date to meet patients' changing needs.

Performance, monitoring and improvement of outcomes

An effective critical care service ensures prompt, appropriate admissions. Patients were admitted and received care and treatment according to national guidelines and this was monitored. The ICU had clear criteria for patient selection and senior staff said the system was effective. There were concerns about delayed patient discharge - see 'Leaving hospital' below.

Staff, equipment and facilities

Staff had appropriate training to provide effective care and confirmed that training and skills development opportunities were available. There were enough appropriately trained staff to meet patients' specialist needs. We were told that, while a number of staff vacancies existed, many had been filled following an international recruitment drive. This had resulted in some recruits having less experience and training in ICU nursing. However, we saw a comprehensive and structured eight-week induction programme for the new ICU staff. In addition to the trust's mandatory training programme, which included safeguarding vulnerable adults and infection control, we saw specialist training for ICU staff which included courses in respiratory and cardiovascular care. We saw records showing that the majority of staff had attended, or were due to attend, the training offered.

Staff performance was monitored through one-to-one meetings with a more senior member of staff and an annual appraisal. We were told that there were regular sessions where staff are assessed when demonstrating a particular skill. Poor performance was managed through the relevant trust policy.

Good

Intensive/critical care

Multidisciplinary working and support

Throughout our visit, we saw good communication between ICU staff and other healthcare professionals working in Glenfield Hospital. A range of professionals were involved in patient care, including speech and language therapists, physiotherapists, tissue viability nurses, microbiologists, radiologists and pharmacists. We were told that there was easy access to these professionals. We saw that effective handovers occurred, when a patient is discharged from the ICU to a medical or surgical ward within the hospital. We were told there was effective communication with other hospitals and the ICU was part of the East Midlands Critical Care Network where developments, recurring healthcare themes and results were regularly discussed.

It was confirmed by a senior member of staff that relatives were regularly consulted and kept up to date about their family member's condition.

Are intensive/critical services caring?

Outstanding ☆

Compassion, dignity and empathy

Patients told us they were treated with care, consideration and compassion. We spent some time observing the activity on the ICU. We saw staff having good, appropriate interactions with patients. Such interactions were unhurried and at a pace suitable for the patient's needs. We saw staff introducing themselves to patients. One patient told us: "They are looking after me very well." We also heard feedback that one patient reported back to the ICU that the care was excellent and they did not want to leave the unit. We observed staff treating patients in a kind, calm and respectful manner.

We were told how staff had arranged a special event, away from the ICU, for a patient with a serious life-threatening illness. This had taken considerable planning and resources; however, it told us what extraordinary lengths the team went to in treating patients with compassion.

Patients were treated with dignity and respect. We observed that staff greeted patients every time they entered a room. They engaged with patients to make sure they were comfortable. Curtains were drawn around patients to ensure they had privacy.

Involvement in care and decision making

Nursing staff explained procedures to patients and reassured them. Staff respected people's rights to make choices about their care. Patients told us that they were kept informed about their treatment and that doctors provided them with updates during ward rounds.

Relatives were involved in patients' care. The ICU had a quiet room and a sitting room for relatives. As the ICU provides care and treatment for patients who live further afield than Leicestershire, a display screen provided information about the local area, amenities and facilities. This information was regularly updated by staff working within the ICU. On-site accommodation was also available for relatives, if needed. We were told that staff could access the chaplaincy services for patients and relatives, catering for all denominations.

Trust and communication

Throughout our visit, we observed that patients' confidentiality was maintained at all times. Discussions which occurred at the patient's bedside were discreet and could not be overheard by other people on the ward. Other discussions were held at the nurses' station or in offices, so that they could not be overheard. This told us that staff took steps to ensure patients' confidentiality was maintained.

We reviewed patients' records and saw that the notes were written in a respectful way about patients. The notes, including assessments and care plans, were very detailed and provided a clear picture of the care the patient required and received. We saw the adult ICU recording chart at the end of each patient's bed. This chart was developed by the University Hospitals of Leicester NHS Trust's ICU service, and contained important information about patients' physical observations and any interventions given. This chart was designed so it could be folded over when not in use to preserve patient confidentiality. The charts we reviewed were comprehensively completed and gave a clear picture of the patient's condition and treatments received.

Patients received adequate nutrition and hydration in the ICU. Records were kept of the amount of fluids patients drank to ensure that they remained hydrated. Patients told us the food was good and choice was offered.

Good

Intensive/critical care

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

We saw information about the trust's Patient Information and Liaison Service (PILS) team displayed in public areas. The team can deal with queries, concerns, and complaints. In addition to this, we saw that an adult intensive care patient survey was available for patients and their family to complete. We saw there was also an 'Ask Matron' system in place for staff to leave comments and questions for the matron. The staff we spoke with were aware of the trust's complaints procedure.

Vulnerable patients and capacity

Where patients could not fully understand or be involved in decisions about their care, the unit ensured that treatment decisions were made in their best interest, and that relatives and support networks were involved. Staff were aware of the need to comply with the Mental Capacity Act 2005.

Patients were given comprehensive information on how to manage their condition or respond to concerns. General information leaflets on the wards were, however, only available in English, although information in other formats or languages could be requested or downloaded from the trust's intranet.

We were told that bereavement sessions for families whose relative had died were held twice a year. This gave families the opportunity to discuss their experience and to also ask questions. The consultants told us they see relatives, if requested, to talk about the care that was given and the reason for the death.

Leaving hospital

The unit responded to changes required to keep people safe. The majority of discharges from the ICU were to a medical or surgical ward. We were informed that the ICU does not discharge patients after 6pm, due to the risk associated with the numbers of staff and services available out of hours to support those patients should their condition deteriorate.

Are intensive/critical services well-led?

Outstanding

Governance arrangements

We examined the communication systems within the ICU. There were handovers and ward rounds which specifically discussed patient care. At a department level, there were various information-sharing meetings, including monthly morbidity and mortality meetings, audit meetings and clinical management group meetings. This told us that there were systems in place for the regular sharing of information.

Leadership and culture

The ICU was very well-led. We saw evidence of highly visible leadership within the ICU. The nurse in charge wore a name badge which meant they were easily identified to patients, staff and visitors. We were told that the matron regularly visited the ward. Senior managers and clinicians had an excellent understanding of the systems, processes, policies and performance of their department. The staff were a strong and cohesive team. All staff were involved in monitoring quality of the units and there was a willingness to respond to change. Monthly meetings demonstrated that staff openly discussed concerns about the service and clinical care, and how the service could improve. This demonstrated that the leadership within the ICU at Glenfield Hospital was to a high standard and robust.

Learning, improvement, innovation and sustainability

Good practice was shared across all ICU's provided by the University Hospitals of Leicester NHS Trust. We saw that up-to-date, current information, research and developments in ICU were stored on the trust's computer system, and could be accessed by staff working within the ICU. This meant that staff had access to current information relating to the specialist care they were providing to patients.

We saw that the ICU had a comprehensive business continuity plan which gave details about how patients' care would continue to be provided in the event of an emergency situation. Such situations included, for

example, an electricity power-cut, and disruption to the supply of medical gases. This told us that the trust had risk-assessed vital services and had put in place contingency arrangements if such services failed.

Good

Services for children & young people

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

Information about the service

The paediatric intensive care unit (PICU) is a 12-bed unit and a designated extra corporeal membrane oxygenation (ECMO) centre for patients with critical heart or lung conditions. The unit takes children aged between 0 and 18 years, but children aged 16 to 18 are given the choice of whether to be admitted to the children's or the adult's service. At the present time, seven beds are fully funded, but this is not meeting demand. There is a plan in place to increase this capacity by one bed per year.

Ward 30 is a 13-bedded dedicated cardiothoracic ward. It is a clean, bright, well-maintained ward with a well-equipped playroom for all ages. Just off the ward is a parent unit containing 12 parent bedrooms (five for use by PICU parents), a kitchen with a microwave and tea/ coffee-making facilities, sitting area and shower facilities.

Summary of findings

Services in the PICU were safe. This is because there was a culture of reporting incidents, reviewing and learning from them. Staff were able to provide examples of actions taken as a result of incidents being reported. The unit was clean and there was adequate staffing on the day of our inspection.

Care was monitored for effectiveness and scores were within the target range. Plans of care were well documented and updated to reflect the current needs of the children. Parents felt involved in care and there was good team working across disciplines.

Parents reported good experiences of care provided by the service. All staff were described as caring and responsive to the needs of the child. The senior managers were supportive of staff and all levels of staff were aware of the trust's visions and values.

Good

Services for children & young people

Are services for children & young people safe?

Good

Learning and improvement

The matron reported an embedded culture of incident reporting on the ward and in PICU, where staff received training on their individual responsibilities to report incidents, and how to do so. Staff used the Datix software to record patient safety incidents and these were reviewed by the matron before going to the quality and safety team. All incidents were reviewed and discussed at the monthly band 7 meeting and learning disseminated trust-wide to the whole paediatric team. The matron stated that it was a priority to ensure learning from incidents and that feedback was given to all involved. A parent confirmed this, stating, "Last year there was a medication error. The doctor is being investigated and we have been told we will be told the outcome". Staff reported that they received feedback in person and in ward meetings about any incident or issue they had raised.

Systems, processes and practices

Infection control

An infection control audit was carried out on Ward 30. All surfaces, bathrooms and clinical areas were neat and clean with 'I am clean' stickers indicating an up-to-date cleaning schedule. Hand-washing sinks were fully equipped with highly visible hand hygiene instructions. In accordance with infection control guidelines, all staff were bare below the elbows. All equipment in bed spaces was clean, dust free, covered and ready for use. No soft toys were present in the ward and all toys in the playroom were washable, clean and in good working order. There was a plentiful and readily available supply of personal protective equipment.

Although the infection control audit was good, there were two issues highlighted for immediate action – one was the removal of milk powder to a lockable location and the advice to lock linen cupboards.

Staff were also advised to consider relocating the washer-drier currently located in the sluice – a dirty area. Parents said, "The ward is sparkling. I have never seen any dirt" and another, "I have been coming [to the ward] for six years and have never seen any dirt".

Monitoring safety and responding to risk

At the time of the inspection there were six patients on the ward with the agreed staff to patient ratio. There was one nurse per patient in the PICU. Staff did not highlight staffing as a problem on a day-to-day basis, although the matron identified recruitment as an ongoing issue.

Staff stated that they were well supervised and supported, had completed their mandatory training and were up-to-date with their annual appraisals. They reported that the ward managers were approachable and dealt with any concerns and issues swiftly, providing feedback during team meetings or in person. They reported that the matron was highly visible; she visited the PICU and the ward three times per day. Staff reported excellent relationships between medical and nursing staff.

Are services for children & young people effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

In the ward office there was a quality metrics board for all staff, indicating scores of 97% to 100% on all areas, with associated action plans for improvement. These areas included risk assessment, pressure areas and infection control. The parent satisfaction score was 94% for those who would recommend the service.

The latest National Paediatric Intensive Care Audit Network (PICANET) report showed the outcomes of children's intensive care in Leicester are improving and are well within the expected limits. An audit undertaken, because of an apparent increase in wound breakdown following surgery in 2009, showed an increased incidence of wound breakdown. Following the implementation of changes in care a re-audit was undertaken. This showed a marked reduction compared with the previous audit, especially for the serious deep surgical site infection cases. The outcomes are within the limits published and demonstrated the effectiveness of the wound care package implemented. The National Congenital Heart Disease Audit of surgery showed that the hospitals outcomes are in line with the national standards and for some above the national rate.

Good

Services for children & young people

Performance, monitoring and improvement of outcomes

The standard of documentation on all cases reviewed was excellent. Nursing documentation showed fully completed, legible entries in patients' notes and comprehensively completed care plans, fluid balance charts and observation charts. Medical and nursing histories were thorough, all risk assessments were fully completed and there was evidence of regular updating and review. Medical notes recorded clear diagnosis and management plans. There were multiple entries from all the multidisciplinary team involved in the children's care and progress notes were timely and comprehensive. All discussions with parents/ carers were recorded in the notes. There was evidence that issues regarding consent and parental responsibility are clearly documented before surgery.

Multidisciplinary working and support

In the two cases we reviewed, there was clear documentary evidence of good communication between the hospital and the child's GP and referring hospital. There was also a clear record of the multidisciplinary meetings held before the planned surgery, where the views and contributions of all staff involved in the child's care were considered, and a plan of care devised and discussed with parents and children, where appropriate.

Are services for children & young people caring?

Outstanding ☆

Involvement in care and decision making

Our review of patients' notes showed that parents are fully involved with decisions about care and parents confirmed this, stating, "You are not told what to do – and my partner asked them 'what would you do?' They replied, 'We can't tell you what to do but we advise.' It is great to have complete trust in their advice and their opinions". Parents reported feeling "safe" and that their children were receiving the "best possible care". One father said, "I have lots of information and we have trust in the surgical team". Parents said that they were always fully informed of procedures and, ''Investigations are done quickly and when they say they are going to be done".

Trust and communication

Without exception, the 25 parents told us that they were extremely happy with the quality of care they had received when on the ward or in the unit. One mother told us, "staff are amazing", another commented, "I would not get through the day without the staff – they are professionals, but they feel like family". A parent of a child (6 years) who had been coming to the ward since birth said "you can't beat the quality of care", adding "we all know each other well. It is brilliant and intensive care is fantastic. We have not had any major issues".

We saw staff talking with parents and children. They all displayed a professional and friendly manner and the atmosphere on the ward was calm and quiet. One mother said "things are always done quietly". Staff were observed to be approachable and friendly and could be seen taking time to explain things to the family. One parent said, "they don't make me feel silly for asking if I don't understand; they have even drawn diagrams for us". Another said, "they always explain things, they always say we are going to do your obs/medicines now".

There is a clearly displayed information board with the photographs, names and designations of all staff working on the ward, but no medical staff appeared here. All staff had identification badges and the inspection team was appropriately and politely challenged and asked to provide evidence of identity when entering the ward.

Of the medical staff, one parent said, "there have been a couple of times when information has not been conveyed sympathetically" and another stated, "we are a little confused about the surgery tomorrow" but both acknowledged that they could ask for further clarification and generally communication was effective and sensitive.

A child who is a long-term patient simply said, "It's lovely here" and his mother added that it was "one of the nicest hospitals I have been to". All parents said that the teamwork displayed between staff made it feel like a "family" and that "your child was important".

Emotional support

The play therapists provided activities for children in a group and on a one-to-one basis. Each child had an age-appropriate plan aimed at normalising their time in

Good

Services for children & young people

hospital. Play was used to support the physical, social, emotional and sensory requirements of each child but also to help prepare children for investigations and surgery, and for painful procedures and blood tests.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

One mother was particularly happy with the care she herself had received: "I have support with breast feeding from the midwife". There was a poster on breastfeeding in the ward and a selection of leaflets on health topics, specific health conditions and information about the hospital. These were available on the ward and the PICU. Some were available in other languages, but some were only in English. Staff reported having access to interpreters for those patients whose first language was not English.

Access to services

Two of the parents spoken to during the inspection were not local and reported that the communication between their home services and Glenfield Hospital was excellent. They reported having, "good communication about what is going to happen before we came in". Another parent said, "What was really good was that the baby was first in Nottingham but there was great communication between the services and another trust to get her here". Some parents could not stay with their child all the time, but stated that, "we are updated whenever we come in".

All parents said that the facilities for parents were excellent. One mother said, "it is a lot easier having a bedroom" and another said, "it is fantastic. Everything we have needed, we have got without even asking". However, two long-term parents said that it was very expensive having to "live" in the hospital, "It is very expensive with a child in need of long-term hospital care, car parking is £50.00 per month as well as other expenses. We have had to put our mortgage on hold".

Leaving hospital

There was clear evidence in the notes that discharge planning happened at an early stage and involved the whole multidisciplinary team. Correspondence in the notes for two longer-term patients provided evidence that great care was taken with discharge arrangements and establishing appropriate care within the community setting, sometimes considerable distances away, should it be required. Very detailed discharge letters were seen in patients' notes.

Learning from experiences, concerns and complaints

There was information on the ward, in six different languages, about how to make a complaint. One parent told us, ''We feel comfortable raising concerns".

Are services for children & young people well-led?

Good

Vision, strategy and risks

Staff confirmed that they were fully supportive of the new trust 'vision' and received regular communication via the chief executive, the matrons and ward managers.

Governance arrangements

Documentation seen on the ward confirmed that governance arrangements were in place. An information noticeboard in the staff office displayed the quality metrics as well as useful up-to-date information about the unit and the wider trust.

Leadership and culture

The matron reported that the new trust board was very supportive of the children's service at Glenfield. She stated that budgets had been reviewed and readjusted and that the board had allowed them to recruit more staff. Despite, this, recruitment is still an issue, but this is more about the national picture. Matron reported that national recommendations for staffing levels in the ward and PICU are adhered to and that she works closely across the whole service to address any difficulties. This was confirmed when speaking to staff who did not feel that there were staffing difficulties on a day to day basis. The matron stated she was very proud of her nursing team, many of whom had been working on the unit for many years. She reported good morale and good working relationships, a view endorsed by the staff spoken to on the day.

Good

Services for children & young people

Learning, improvement, innovation and sustainability

Nursing staff reported that team meetings were well embedded, regular and enabled full discussions of any issues raised by any members of staff.

Good

End of life care

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

Information about the service

University Hospitals of Leicester NHS Trust had a specialist team led by consultants in palliative care medicine and specialist palliative care nurses, covering all three main hospital sites. Palliative care was provided across all wards at the hospital, seven days a week, with access to specialist advice out of hours. The palliative care team provided direct patient care where palliative needs could not be met by the hospital team. The team also provided training and support to medical and nursing staff and was involved in developing and implementing patient pathways.

The bereavement service included a trust-wide, multicultural chaplaincy service supporting people during end of life care, and providing practical and emotional support to families after the death of a relative.

We spoke with nine patients and 24 staff members, including a palliative care consultant, palliative care nurse specialists, doctors, chaplains, bereavement coordinators, mortuary technicians and porters. We observed care and treatment and looked at seven patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we received performance information from the trust.

Summary of findings

Patients received safe end of life care. Patients who were nearing end of life were identified early so that they could be supported to make decisions about their care. Staff were knowledgeable and experienced in providing care that met patients' needs.

The hospital had actively listened to and took action following feedback from patients and relatives about end of life care. The chaplaincy reflected the cultural diversity of the patients and responded to their individual needs. There was board-level support for the role of the palliative care team and end of life care within the hospital.

Good

End of life care

Are end of life care services safe?

Good

Safety and performance

Patients received safe palliative and end of life care. Where patients had chosen to receive their care at home or at another care setting, suitable support services were implemented to ensure safe care. The records of seven patients who were receiving palliative or end of life care at Glenfield Hospital demonstrated that they had been assessed for their needs and were being treated appropriately for their condition. Pain relief, symptom management, nutrition and hydration were being provided according to patients' needs.

The discussions between medical staff, patients and their relatives around care and treatment during end of life care was documented clearly and the reasons for the decisions around resuscitation were documented in the patients' notes. The 10 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms we reviewed had been signed by the appropriate doctors.

Learning and improvement

The service was focused on safety. Staff reported incidents and told us they received feedback and shared the lessons learned. We spoke with a bereavement officer and their manager; they both demonstrated a good understanding of the procedures and their responsibilities. There had been monitoring of the effectiveness of these procedures and staff had been tested during their appraisals, and it was found that the procedures were robust.

Are end of life care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

End of life care followed government guidelines. In accordance with national guidelines, the Liverpool Care Pathway for end of life care was no longer in use at Glenfield Hospital. In its place the palliative care team had created guidance for staff to support individualised care for dying patients. The guidance recommended a multidisciplinary assessment for patients who were in their last days of life. The guidance covered recognition of the patient's condition and preferences for care, sensitive communication, review of treatments and investigations and ongoing assessments of their needs.

Performance, monitoring and improvement of outcomes

The palliative care team is in the process of implementing an 'AMBER care bundle' on 15 (trust wide) wards. The AMBER care bundle helps prompt staff to identify patients who have an uncertain recovery and are usually still undergoing active treatment. The identification of these patients is a multi-disciplinary process, with the patient's own consultant retaining overall responsibility for clinical decisions. The care bundle prompts the team to consider, in conjunction with the patient and their next of kin, decisions about ongoing care and treatments, including preferences around place of care now and in the event of deterioration or recovery. The AMBER care bundle promotes regular communication between professionals, patients and their families. The end of life facilitators regularly attend the ward where the care bundle is being used to support staff to identify appropriate patients and provide education and training. This has involved around 300 (across the trust) patients since November 2012.

From October 2013, at least 50 patients (at this site and Leicester Royal Infirmary) receiving palliative care from clinicians and the trust's specialist palliative care team hold their own 'Emergency Health Care Plan', which contains information about their key clinical problems and individualised management plans. These are created in conjunction with the patient and a clinician, frequently a Palliative Care Specialist. Where necessary, a patient's preferred place of care and resuscitation information is also recorded. This initiative placed the patient at the centre of their care and provided a holistic view of their care as it records previous discussions and decisions and promoted continuity of care.

The palliative care team was actively involved with medical teams for patients with cardiac and respiratory conditions and cancer. The teams worked together to recognise if patients' conditions were worsening. There was a clinic set up to discuss future treatment options.

Multidisciplinary working and support

Following the death of a patient in the hospital, the team of bereavement officers liaised with medical staff to

Good

End of life care

coordinate the provision of essential documents. They met with families in the bereavement suite. The bereavement officers supported families with practical guidance about the services available at the hospital and ensured they received their relatives' personal belongings and completed essential documents.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Staff were sensitive to the privacy needs of relatives and patients at end of life, patients were accommodated in quiet areas of the wards where possible. We observed that one patient had been identified as requiring end of life care; the doctor had discussed the care with the patient and their family in their own language. The patient had chosen the ward as their place of care, a side room was made available and a recliner chair was acquired for relatives to stay in the room with them.

Palliative care nurses were actively involved in the training of all staff in end of life care. End of life care training was incorporated into the healthcare assistants' induction programme. Staff were trained in caring for people after they had died to preserve their dignity in line with national guidelines. A recent initiative to aid staff was the production of a 'Care after death' checklist card for all staff.

Involvement in care and decision making

The palliative care team were involved in the chief executive's Listening into Action initiative to improve care. The team were collecting patient and carer feedback for the six months up to May 2014 to learn about their experiences and provide solutions and improvements. The patients we spoke with all said that the nurses were friendly and made time for them. One patient told us, "There is not a bad thing to say". The relatives of another person receiving end of life care told us, "We were involved and informed all along the way with regards to my dad's care. Staff were brilliant".

Emotional support

Patients' spiritual needs were met by the chaplaincy team who had 11 chaplains with Christian, Roman Catholic, Muslim, Hindu and Sikh faiths. A team of volunteers worked closely with the team to provide pastoral support for patients. There was further access to community faith groups when the chaplains were not on duty. The hospital had a multi-faith room with washing facilities and a chapel.

The intensive care unit provided a bi-annual bereavement support group for relatives to discuss their experiences with other relatives and staff.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patients were involved in making decisions about their treatment and place of care. Patients were also fast-tracked to get immediate funding to facilitate the right home care package or nursing home, depending on their wishes. The palliative care team could make direct referrals to the Hospice at Home team. Patients were discharged with patient-held records that informed the community teams of their medical condition, details of their palliative care and their preferences for care and treatment. These records were accessible electronically on the wards, in A&E and out-of-hours medical care departments.

Vulnerable patients and capacity

There had been learning from previous safeguarding incidents within the bereavement service, where procedures were put in place to protect patients who had no next of kin or traceable family. The records of each death had an electronic record that could not be closed until all the procedures had been followed and signed off. When the team established that there was no next of kin, they arranged contract funerals and a referral was made to the treasury solicitor.

Access to services

The chaplaincy responded to people's cultural and religious beliefs. Where people had no specific needs, the team provided a 'listening friend' to help provide a support network when needed, for example, to help facilitate family reconciliation. There were alerts on the electronic records that triggered the chaplaincy to a person's needs, such as long in-patient stays, previous chaplaincy visits, or a referral

Good

End of life care

from staff. The members of the chaplaincy team could speak a number of languages, including English, Urdu, Gujarati, Arabic, Hindi, Kutchi, Punjabi, Marathi and Polish, which reflected the patient population at the hospital.

Where patients required a burial within 24 hours of their death, or repatriation for cultural or religious reasons, the hospital had systems in place to recognise that this would be required and to release people for burial in a timely way. The trust had achieved 91% of requests for immediate release for burial in the last year.

Are end of life care services well-led?

Good

Leadership and culture

The chief nurse of the hospital took an active role in supporting the palliative care team to put processes in place to improve services. The chief nurse represented the palliative care team on the trust board.

Learning, improvement, innovation and sustainability

The palliative care team were active members of the Leicester, Leicestershire and Rutland working group for end of life care, which included community palliative care groups, the hospice and the clinical commissioning groups. The working group worked strategically to plan and implement an alternative to the Liverpool Care Pathway, a guide to anticipatory prescribing, and a unified 'do not attempt cardio-pulmonary resuscitation (DNA CPR) policy and procedures.

Staff facilitating the 'AMBER care bundle' represent University Hospitals of Leicester as part of a national 'Route to Success: Transforming End of Life Care in Acute Hospitals' initiative to improve end of life care. All these records were audited and the outcomes are shared with other hospitals taking part in the same initiative. The end of life care facilitators worked closely with other hospitals to share good practice and overcome barriers.

Good

Outpatients

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

Information about the service

The University Hospitals Leicester NHS Trust provides outpatient services at Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital. Appointments are for a variety of specialties. At Glenfield Hospital, 138,858 people had outpatient appointments; 41,224 of these were new patients and 97,634 were follow-up appointments. Although the trust has had difficulty in meeting the 18 weeks referral-to-treatment target, Glenfield was achieving this well.

Summary of findings

We found the outpatients services to be safe. Staff followed correct procedures for the use of personal protective equipment and were aware of emergency procedures.

The hospital was meeting referral-to-treatment time requirements for specialty clinics and audit was used to ensure standards were monitored. We saw people were respected and that their dignity was maintained.

People told us that they felt cared for and thought their care was good. The department was well-led by a visible matron and staff told us they felt supported in their work.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

Staff in the main outpatients department we spoke with were aware of incident reporting procedures and they told us that they received feedback about incidents, either at team meetings or via email. Incidents were reported via the Datix electronic healthcare reporting system. In one of the specialty clinics, we saw an action plan formulated following an incident, identifying the actions taken to ensure that the situation was corrected.

Systems, processes and practices

The environment looked clean and well maintained, although staff raised concerns about the quality and frequency of cleaning. There was a resuscitation trolley in the main outpatients department. Staff were able to tell us its location and were clear of their role and responsibilities in the event of a medical emergency. We checked the contents of the resuscitation trolley and found them to be correct, with the audit checklist and medicines and fluids within their use-by dates.

Staff used personal protective equipment appropriately and there were hand-sanitising dispensers available for staff and public to use. All medicinal products were kept securely locked. Staff had attended safeguarding training and all staff we asked about safeguarding had a good knowledge of what action to take if they had concerns.

With patients' and carers' consent, we saw orthodontic treatment being given. We saw that the clinician washed their hands and wore gloves and mask. Equipment for single-use only was disposed of correctly. For the patients' safety, an appropriate mouth guard was used and dark glasses to protect their eyes.

Monitoring safety and responding to risk

There were enough staff on duty at the time of our visit. During our inspection, there were a number of different clinics within main outpatients and specialty clinics. Some clinics were nurse-led. These were operated by staff with extended skills who had received the appropriate training to undertake that type of care, such as nurse prescribing. Staff in outpatients had received training in the Mental Capacity Act 2005.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Performance, monitoring and improvement of outcomes

We saw that clinical audit was carried out in the department. The matron for main outpatients had adapted the trusts nursing metrics audit tool so that it was suitable for the department and this was being rolled out to all outpatients departments. The audit ensured that standards within the department were monitored regularly.

Staff, equipment and facilities

Staff in the department had access to training, including mandatory training and also National Vocational Qualifications (NVQs). Senior staff showed us how they determined the staffing needs based on skills required to effectively manage the clinics. Some staff had received further training which enabled the department to offer additional services, including nurse-led clinics, and allowed for flexibility of staffing across departments.

Multidisciplinary working and support

The outpatients department worked with external professionals to ensure continuity of care for patients. There was information for referring people to community nursing services and referral forms containing the necessary information to communicate patients' needs effectively. We saw a member of staff referring a patient to a community matron for ongoing assessment and support. They discussed the patient's requirements and ensured that the patient understood the referral.

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients we spoke with told us they were happy with their care. They were not rushed; they were given time and information to make a decision. They told us that staff had kept them informed about what was happening. If there was a significant delay for patients, then refreshments and snack boxes were made available.

Good

Outpatients

The first consideration for all members of staff when questioned was the care and welfare of patients. We observed staff talking to patients in a respectful and polite way. There was positive engagement with patients.

There were quiet areas for patients who may have received difficult news and staff told us how they supported people in those circumstances. Staff introduced themselves when talking to patients and took time to check patients' details and inform them if there was a delay in clinic and how long the delay was. Confidentiality was maintained as notes were kept out of sight and staff were discrete when talking on the telephone. In the outpatients' waiting area, there was information for carers listing help and local support available.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Access to services

Although the trust had been failing to meet its 18-week target for referral-to-treatment time for outpatients, specialties with clinics at Glenfield Hospital, including cardiothoracic and cardiology, were meeting or exceeding their targets. We spoke with staff about the volume of patients they saw in clinic. The daily average for people seen in clinics across the trust was most recently 3,210.

Staff told us that overbooking and cancellation of clinics occurred and they described the informal way they rebooked patients to ensure they were seen in a timely way. One person told us that they booked their retinal screening by email which was quick and easy. One clinic manager told us that, although they were responsible for ensuring the smooth running of the clinic, they were not always told why a clinic was cancelled. There was poor communication between departments responsible for ensuring that clinics took place.

The service manager told us that they were developing an electronic system and employing a member of staff to manage the booking of clinic rooms. This software would highlight empty rooms or clinics, enabling the effective use of resources and staff. They anticipated this would be in use by February 2014.

The matron for general outpatients collected information on the service via a postcard system called Message to Matron. The service received more than 1,500 responses across the three main hospital sites. The most frequent area of concern was delays in being seen in clinic. We spoke with a member of staff responsible for clinics who confirmed that late cancellations sometimes occurred and that it might not be possible to contact patients before they arrived in clinic. These meant patients may make an unnecessary journey to the hospital and then have to rebook their appointment. The NHS Choose and Book online and telephone service lets patients choose their own appointment to suit their needs. We were told that, in some specialties, after a patient had booked their appointment it was triaged and, if they are considered to be lower priority, a different appointment may be offered. This meant that some patients could be given an appointment not suited to their needs.

The trust operated a booking centre that dealt with outpatient's appointments. This service handled approximately 3,000 telephone calls a week and answered 97% within 30 seconds. The booking centre was able to book follow-up appointments and some new appointments, but they were only able to book to allocated slots. Any patients who could not be found a reasonable appointment within the target or at a convenient time were handed back to the specialty clinic to arrange an appointment.

Learning from experiences, concerns and complaints

There was information displayed around the department informing patients and carers about how to make a complaint. Staff we spoke with knew the complaints procedure.

We saw that the Message to Matron postcards were analysed monthly to determine any themes in the issues raised. Most responses received were of a positive nature and the results were displayed prominently in public areas. Where there were concerns that fell within the matron's responsibilities, we saw that actions were taken to address them.

Good

Outpatients

Are outpatients services well-led?

Good

Vision, strategy and risks

In the outpatients department we saw the trust and department visions and values displayed. Staff we spoke with were aware of the vision for the department and future plans.

Leadership and culture

The matron for the main outpatients department demonstrated a strong, coherent vision for the services they were responsible for. They were passionate and enthusiastic about improving the service for patients and demonstrated this through service changes made in response to feedback. There was clear consistency in leadership across the three main hospitals at departmental level. The matron's phone number was displayed in public areas so patients could call them direct with any issues. Staff said they saw the executive team around the department on occasion and regularly saw the matron responsible for their department.

Patient experiences, staff involvement and engagement

All staff felt well supported in their roles and understood their responsibilities. They had regular supervisions and team meetings and said they felt confident to raise any concerns directly with their manager. All staff told us they had received training and many had undertaken further training such as an NVQ to develop their skills. The matron informed us that they had had three different managers over the previous 12 months but that they had been well supported throughout.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. People who use services and others were not protected against the risks associated with receiving unsafe care in the clinical decisions unit due to inappropriate admissions from the main A&E site. Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. People who use services and others were not protected against the risks associated with receiving unsafe care in the clinical decisions unit due to inappropriate admissions from the main A&E site. Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. People who use services and others were not protected against the risks associated with receiving unsafe care in the clinical decisions unit due to inappropriate admissions from the main A&E site. Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients. Regulation 22

Regulated activity	Regulation
Surgical procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients. Regulation 22

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Patients were not protected from the risks associated with a lack of appropriate numbers of appropriately qualified, skilled and experienced staff in the clinical decisions unit care for patients. Regulation 22

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. Patients were not protected from the risks associated with unsafe equipment as equipment was found in the medical wards which was dirty. Regulation 16 (1) (a)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Surgical procedures	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. Patients were not protected from the risks associated with unsafe equipment as equipment was found in the medical wards which was dirty. Regulation 16 (1) (a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. Patients were not protected from the risks associated with unsafe equipment as equipment was found in the medical wards which was dirty. Regulation 16 (1) (a)